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Volume 171, Number 1, January 1987

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Illinois State Medical Society

Volume 171, No. 5
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To Educate is to Persuade



By now, all action teams from hospital medical staffs and county medical societies should have been reactivated and begun planning for this spring's Professional Liability Initiative. In fact, I trust that all legislators have been contacted and initial meetings held. As we learned at the All-Member Conference in November, this time around the going is expected to be extremely difficult.

There are several reasons for this: (1) more emotional subjects than were addressed in 1985; (2) opponents will not be caught by surprise this time; and (3) the Medical Practice Act is up for review.

The concepts—limiting awards to people injured because of medical negligence and interfering in any way with compensation for children—sound callous and self-serving when offered without explanation. We have to keep reinforcing the fact that we are not against persons who have truly been injured because of medical negligence receiving full compensation for all tangible expenses. We do object to the huge variance in awards for the emotional component of jury verdicts.

Why should there be such wide discrepancy in awards for identical injuries? Does the injured party really derive benefit from large noneconomic damage awards, or is the benefit primarily to the plaintiff's attorney or possibly family? We should ask these and other questions, and find the answers. We should continually stress that injured persons must be helped to become as whole as possible, and to live as comfortably as they would have, absent such a problem.

Our opponents know they were not prepared to resist our effort in 1985. They will be ready this spring. Already they have contributed far more than we could raise through IMPAC—to elect candidates sympathetic to their interests. The political makeup of the General Assembly has not changed—just some faces. Accordingly our efforts must increase in volume as well as intensity.

Unfortunately, but of equal importance, the Medical Practice Act is due to sunset in 1987. This is good because our discipline procedures can now be addressed. It could be bad also, in that, groups not presently licensed under the Act will seek to be included and those with limited licenses may attempt to increase their scope of licensure. These matters will demand our attention and our energies.

What I have tried to do, in a brief way, is to impress upon you, the membership of ISMS, the importance of a loud, informed and united voice. We must first educate and then persuade our legislators, the media and the general public that what we seek is in the best interests of all of the citizens of this state. Your elected officers and the staff of ISMS are totally committed to the effort. Please join us. ◀

Jere E. Freidheim, M.D.
President

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Caryl G. Salomon, M.D., Department of Radiology, Loyola University Medical Center, Maywood.

This 66-year-old man has left flank pain following blunt trauma. He has gross hematuria. Blood pressure, pulse and respiration are normal. An intravenous pyelogram was done. (Figures 1A and B)

Figure 1A

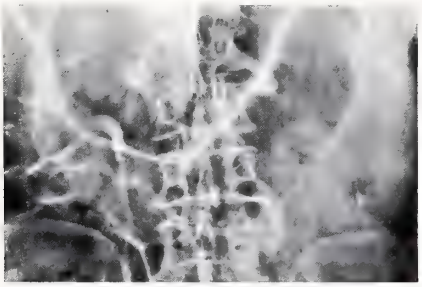


Figure 1B



Figures 1A and B. Intravenous urogram shows abnormal left kidney: (A) 10 minute film; (B) Nephrotomogram.

What further imaging study would provide the most information?

(1) Radionuclide scan
(2) Kidney sonography
(3) Computed tomography
(4) Angiography

(Continued on page 42)

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Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS — Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided during first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS — Observe usual precaution in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE — Take general measures as for any CNS depressant.

SUPPLIED — TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

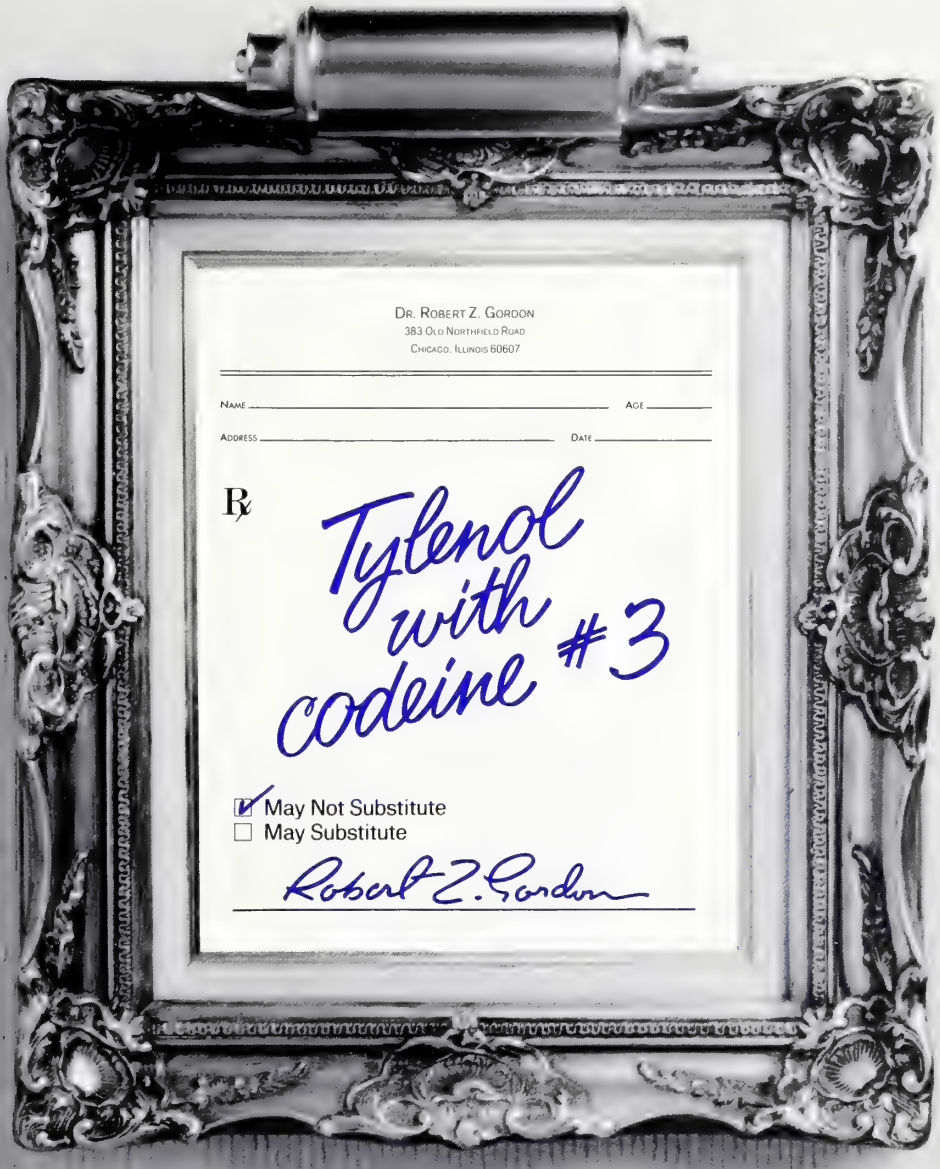
Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.



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Everyone Answers to Someone

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwin began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

Your readership and my watchership—those I watch and to whom I listen—would seem to be very different populations. However, in many ways, they are much the same. This truth was brought home to me with even greater force yesterday morning in the Apollo as I listened to some louder-than-usual grumbling.

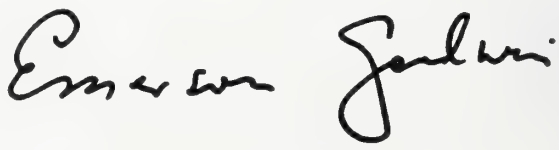
It seems that this particular grumble session started with Raphe and Willard arguing about who was going to fill out the forms for PIK and other governmental programs under discussion. I suppose their greatest problem came with the filling out of the form, but shortly, it became a "picking" contest all its own as they tore into and apart the particular forms in front of them.

At this point, old Asa, who had finished shaking out his blanket-lined, blue denim coat and had pulled up the ear flaps so he could hear and see better, sat down and expressed the opinion that: "There ain't no free spirits at all any more. Somebody (usually the government) has got a string on us all."

With this, almost everyone present began to throw in their two-bits worth, with their individual accountabilities to government, regulator, boss, or who have you. All of this brought to mind some of the things I have read in the medical journals—much the same kinds of complaints about required accountability. That may be DRGs, insurance carriers, or some of the regulatory bodies you folks deal with.

On reflection, I suppose that everyone has to be accountable to someone. The only difference is that the number and strength of the "someones" to whom we, whether farmers or doctors, must be accountable, is growing. In earlier times, the farmer was only accountable to the grain elevator and the physician was only accountable to his patients. Physicians had a little bit of an edge on that, since they had hundreds of patients, while the farmers usually only had one, two or three grain elevators to deal with. What's happened now is that the degree of accountability has gotten a lot more severe, and the clout that can be brought to bear against the individual farmer or physician has become enormous.

However, I am certain of one thing, and that is that we all have to answer to someone. This is much truer now than it has ever been before, and I suspect it will continue to be more and more the truth as time goes on. To paraphrase Asa, we may be free spirits, but we will still have strings. Everyone has to answer to someone and that's a fact. ◀



Yours,
E. Goodwin

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ABSTRACTS OF ACTIONS

November 7, 1986 *ISMS Conference Complex*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

RELICENSURE

The director of the Department of Registration and Education has indirectly indicated his interest in establishing, by rule, the amount of fees charged by the Department of R&E for relicensure of physicians. The director also wants to establish the licensure period by rule. Both of these are currently within statute, *i.e.*, $35 per year, renewable for a three year period at a total cost of $105 per renewal period. The director has further indicated a desire to raise the yearly $35 fee to cover all of the costs of the Medical Examining Committee as well as any additional costs incurred by the Medical Disciplinary Board.

The Board agreed that R&E should not be given rule-making authority to establish either the amount or time frame for physician licensure fees. This authority should continue to rest statutorily within the Medical Practice Act. In addition, the Board agreed that R&E must justify the need for any proposed increase including an accounting of current expenditures prior to its consideration by ISMS.

CHAMPUS

A new organization called the Alliance of State Physician Review Networks has begun to meet in order to address contracting for national programs under the federal government. This new alliance was organized as a result of proposals for a complete overhaul of the CHAMPUS system. Under the reorganization, bidders for the provision of care to dependents of military personnel will compete for regional fixed price or at-risk contracts. There is concern that this activity could present antitrust problems. It is anticipated that the alliance will have to become a legal bargaining entity, such as an IPA. The Board agreed to maintain its present monitoring position with legal counsel advice, continue to follow the situation closely and forward any information to the Illinois AMA Delegation.

DOCTORS OUGHT TO CARE (DOC)

The Medical Student Section (MSS) chapter at the Rockford Campus of the University of Illinois has indicated interest in working with the DOC organization to coordinate local anti-smoking activities. A few other school chapters have also expressed interest.

DOC is a nonprofit organization created in 1977 by a group of young physicians to address social responsibility. They focus on misleading advertising practices for products considered hazardous to health, often launching counter-campaigns using the same Madison Avenue techniques used by advertising companies.

The Board referred the request back to MSS with concerns regarding ISMS endorsement of another organization.

POLICY STATEMENTS

On recommendation of various councils, the Board approved the following:

- ☐ *New Policies* (Resolution will be submitted to the 1987 House of Delegates)
  - Medical Control in Prehospital Care
- ☐ *Amended Policies* (Resolutions will be submitted to the 1987 House of Delegates)
  - Emergency Medical Care, Provision of
  - Immunity
  - Mental Health
  - Nursing Home Inspections
- ☐ *Retained Policy with New Title*
  - Hospital Licensing Regulations retitled "Assistant in Surgical Procedures"
- ☐ *Deleted Policies*
  - Dual Standard of Care
  - Medical Treatment of Alcoholics
  - Reimbursement

OTHER ACTIONS

In addressing various other issues, the Board:

- ☐ Authorized appropriate comment to HCFA opposing changes to the methodology currently used by IDPA to evaluate generic drug products.
- ☐ Endorsed draft rules for mandatory CME and agreed to notify the Department of Registration and Education of this position.
- ☐ Approved guidelines dealing with formal complaints against accredited sponsors of CME for incorporation into the ISMS accreditation program procedures.
- ☐ Agreed not to introduce or attempt to pass the PLI II legislative package in the special session unless there is an indication that the legislature is seriously considering additional tort reforms.

☐ Agreed that an appropriate council should develop ethical guidelines for freestanding centers, HMOs, etc., in which physicians have economic interests.

PROGRAMS

The Board:

☐ Approved the planning and solicitation of sponsors for the 1987 ISMS Physician Games.

☐ Approved the implementation of the 1986/87 Team Physician Awards Program.

☐ Approved the development and implementation of a Sports Medicine Seminar at the 1987 Midwest Clinical Conference.

NOMINATIONS AND APPOINTMENTS

Various nominations and appointments were approved by the Board, as follows:

☐ Named Stephen Sheldon, D.O., Chicago, as coordinator of medical information for the ISMS Child Abuse Education Program.

☐ Nominated Seymour R. Goldberg, M.D., Bloomington, to serve on the IDPH Clinical Laboratory and Blood Banking Advisory Committee.

☐ Reported that James R. DeBord, M.D., Peoria, had resigned as an AMA alternate delegate and that the vacancy will be filled at the next ISMS House of Delegates meeting.

OTHER MATTERS

☐ *Financial Reports*

The Board accepted the August 31, 1986, Financial Statements; October 20, 1986, IMPAC Collection Data; October 15, 1986, Dues Payment Report; and Requests for Changes in Membership Status.

☐ *Directors and Officers Insurance*

The Board previously authorized obtaining a D&O insurance policy for $1,000,000. Additionally, the Board authorized a resolution to the House of Delegates to indemnify officers of ISMS. Similar actions were taken by the Boards of both ISMIS and ISMIE. Recently the Society was informed that the underwriters withdrew their offer and would not provide this insurance. Currently a policy is in place which provides $500,000 of coverage until February, 1987. The market is currently being explored in order to identify new sources of an additional $500,000 coverage.

☐ *IFMC Bankruptcy*

In 1984 a petition was filed in the U.S. Bankruptcy Court by the Illinois Foundation for Medical Care indicating that it had ceased all business operations. This filing proceeded through the court system and on October 7th an order was entered disposing of the assets of IFMC and thus terminating its existence.

☐ *Challenges to Medical Malpractice Reform Act of 1985*

Recently in several separate lawsuits a challenge has been raised by the plaintiff as to the constitutionality of the statutory requirement that every medical malpractice suit have attached to it an affidavit indicating there is a meritorious cause of action. All defense counsel involved have been notified to forward copies of all pleadings to ISMS counsel. Linked to this are arguments from the plaintiff attorneys that no malpractice crisis exists. The Supreme Court in *Bernier* ruled that if there are crises, this must be determined by the legislature and the courts will not decide something of this nature. Since the Supreme Court ruled in our favor, this will be helpful at the trial level of these cases. Another issue which is being raised in some of these cases is the "conspiracy of silence" contention. Other arguments include the unconstitutional delegation of judicial functions to private parties, that special legislation is involved, as well as equal protection and due process theories. These matters are being monitored closely.

Related to this, Mr. Ring, in the *Bernier* case, filed a petition for a rehearing on one element of the initial challenge to the Medical Malpractice Reform Law affecting the issue of collateral sources. The Supreme Court on September 26 denied the petition.

The Governor signed SB 1200 which addresses the issue of insurance reform. At the same time, he called a special session of the General Assembly to run concurrently with the veto session. While there has been broad debate as to the effect this law will have on the general public or insurance carriers, it does not affect physicians in their individual practices.

☐ *IPhA Request for Information*

Recently the Illinois Pharmacists Association asked to meet with ISMS to discuss the issue of physician dispensing of pharmaceuticals in their private offices. There was a concern on the part of the pharmacists that this was a profit-oriented activity. The request asked that ISMS meet to discuss the issue of commercial enterprises marketing dispensing packages to physicians. Based upon legal counsel advice IPhA was informed that "The Illinois State Medical Society not participate in such discussions," based on a concern that this could be construed to be an attempt to agree upon an economic course of action, which could violate antitrust laws. Also, physician drug dispensing is lawful under the Medical Practice Act.

☐ *Informational Reports*

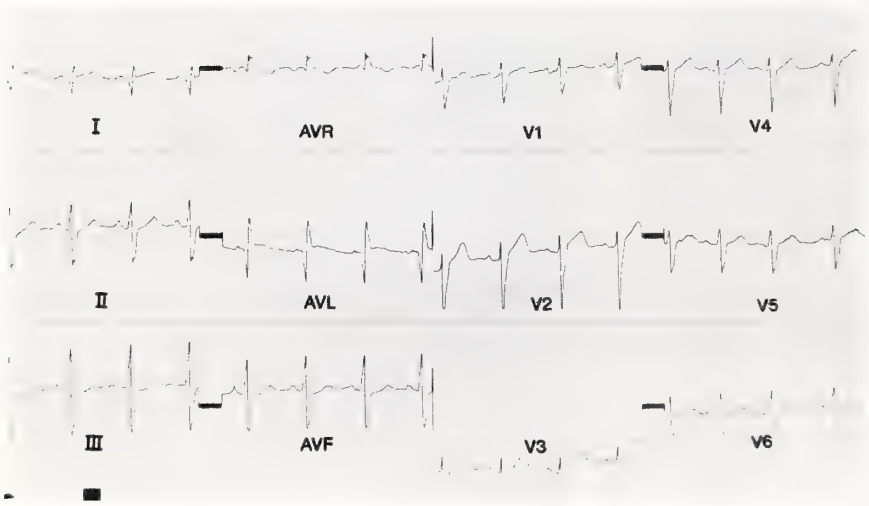
Informational reports were presented by the Committee on Health Planning, Committee for the Impaired Physician, ISMIS, ISMIE, Resident Physicians Section, IMPAC, Speaker and AMA Delegation Chairman.

NEXT MEETING

The next Board of Trustees meeting was set for January 17, 1987, at ISMS Headquarters. ◀

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was a 67-year-old woman who had an acute anterior wall myocardial infarction four years earlier that had been complicated by congestive heart failure and ventricular arrhythmias. Until two months ago, the patient had done well on digoxin, diuretics and vasodilator therapy. Dyspnea on exertion had gradually worsened, until she was so easily fatigued that she could no longer do her shopping. Orthopnea and ankle swelling had developed.

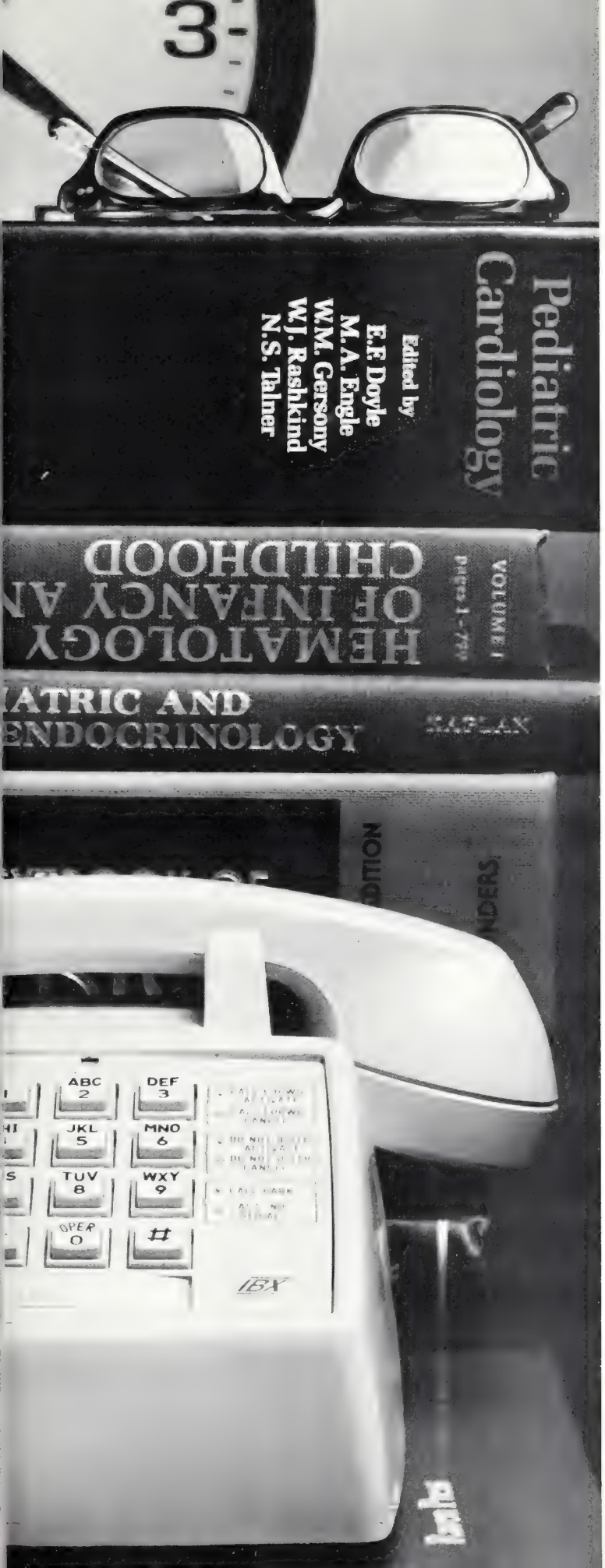
Physical examination showed neck vein distension, bibasilar crepitant rales in the lungs, and loud atrial (S4) and ventricular gallop (S3) sounds. There was 2+ pretibial and ankle edema bilaterally. Chest x-ray showed cardiomegaly and pulmonary vascular redistribution. This twelve lead ECG was obtained.

Questions:

1. **The twelve lead ECG shows:**
   - A. Accelerated idioventricular rhythm.
   - B. Atypical complete left bundle branch block.
   - C. An anterolateral wall myocardial infarction.
   - D. ST segment elevation compatible with a current of injury or a left ventricular aneurysm.
   - E. All of the above.

2. **Appropriate therapeutic measures in this patient could include:**
   - A. Rule out a new myocardial infarction.
   - B. Two-dimensional echocardiogram or radionucleotide angiogram.
   - C. Increase medical management, *e.g.*, diuretic dose.
   - D. Cardiac catheterization with left ventricular and coronary angiography.
   - E. Left ventricular aneurysmectomy.

(Continued on page 48)



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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

In Search of an Exit

"Before a plane takes off I've spotted all the exits. It's second nature for me to do the same whenever I go into a building for the first time. wouldn't consider entering into a contract that didn't have an 'exit clause' I could live with."

An Informed Physician

You might need 30 minutes to read a typical alternative delivery system contract. Your accountant may spend a couple of hours analyzing its potential financial impact on your practice. Legal advice from your attorney and contract negotiation may take a couple of hours more, depending upon the complexity of the plan.

But in the few seconds needed to sign on the dotted line, you become legally bound by all the contract provisions. The contract that took just seconds to "enter" could take years to "exit." It all depends on the termination provisions.

The termination clause of any contract should be given serious consideration; this is especially so in HMO and PPO contracts. Not only is this a new type of contract, but the business entity with which the physician is contracting may well be a new corporation. The provisions of a contract may increase the physician's professional liability exposure, and may also present new types of liability. The compensation schemes are often also new. When they're tied to patient volume or utilization of medical services, the outcome is difficult to predict. A predictable body of judicial decisions involving alternative delivery systems has yet to emerge. However, it is clear that the same "standard of care" that applies to private patients also applies to contract patients.

Even the best financial and legal analysis and advice cannot guarantee that the contractual arrangement will be suitable for you. You or the IPA may later become unwilling, unprepared or reluctant to practice medicine within that particular system and may want to terminate the contract. The utilization restrictions of a cost containment program may become, in your medical judgment, harmful to patient care. If you're compensated on a capitated basis it's possible that the capitation is no longer adequate to provide quality care because of changes in the enrolled population. A change in the IPA board of directors could affect interpretation or enforcement of policies and procedures, bringing about a different consensus, which you do not share, regarding the practice of medicine. Similar changes could occur if the HMO or PPO is acquired by another business entity. Maybe the expected increase in patient volume has not happened, so that the percentage discount of your fees has made your practice financially untenable. For whatever reason, you may want out.

As easy as it was for you to "enter" the contract, it sometimes takes even less effort to remain bound by the contract. Often you have to do nothing at all. In other words, some contracts do not automatically end at an expiration date. Rather, the contract *automatically renews* unless you give the HMO or PPO advance notice. A typical termination clause may look like this.

> The contract commences on December 1, 1986 and ends on November 30, 1987. The contract is renewed automatically from year-to-year unless either party gives written notice of intent to terminate the contract at least 120 days before the anniversary date.

Under this provision, if your decision to terminate the contract and accompanying written notification occurs after July 3, 1986, you would be locked into the contract until November 30, 1988—another 16 months. Contracts which provide for automatic renewals may also foreclose renegotiation of fees and other contractual terms.

By giving the required advance notice the physician or IPA may successfully avoid the "automatic renewal" lock-in clause. But that doesn't guarantee that the contract will indeed terminate on the anniversary date if the same contract contains a clause which may look like this.

> At the election of ABC HMO no termination is effective and this contract shall continue with respect to any Plan or Enrollee until the obligations of the ABC HMO have terminated or other service arrangements have been made by ABC HMO. Such continuance shall not exceed six months.

The same effect is achieved by this clause.

> Following termination Physician shall continue to provide Covered Physician Services to Plan Enrollees so long as any ABC HMO contract providing for enrollment in the Plan remains in effect, which shall in no event exceed fourteen (14) months from the time the termination or notice of termination is effective.

In effect, the physician's contract term is tied to the enrollee's contract term, and may not be terminated until the enrollee contract term expires. Again, the physician may be foreclosed from renegotiation of fees and other terms during this "extension" period.

Some contracts give the HMO or PPO the right to "automatically" or "immediately" terminate the contract, without giving a corresponding right to the physician. For example, some contracts provide that the physician shall fully cooperate with undefined peer review, utilization review or other programs, and that failure to abide by any review decision is grounds for immediate contract termination. Immediate termination may also result if the physician participates in any act or omission which the HMO or PPO determines to be harmful to its reputation or activities. A contract may give the HMO or PPO absolute discretion to immediately terminate the physician contract if he has not fully complied with the contractual obligations. Such termination clauses generally do not give the physician the right to appeal the grounds for termination.

Suppose either you or the HMO or PPO has terminated the contract. Does the contract termination automatically terminate the physician/patient relationship? *No.* A malpractice claim may arise if an injury results from the physician's refusal to continue treatment through a period of later complications. The physician's "standard of care" includes providing treatment to patients needing further care. The refusal to provide further care without giving the patient a reasonable time to find substitute care constitutes patient abandonment.

Because you're an informed physician, who recognizes the complexity of these contracts, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you objective comments on any HMO, PPO or IPA contract at no cost. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

MEMBERSHIP FORUM

Membership Forum is intended to serve as a communication tool for ISMS membership. The editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, Twenty N. Michigan Ave., Suite 700, Chicago 60602.

More on Influenza A and Pneumonitis

Editor's Note: This 1986 correspondence, which was received too late for publication during last year's flu season, was held for timely publication in 1987.

Dear Sir:

The timely article by Riseman *et al.*, in your January issue (*IMJ* 169:1, 19, 1986) emphasizes the importance of recognizing influenza A as an etiology for pneumonitis. In support of their observation, we recently evaluated a cardiac transplant recipient for interstitial pneumonitis, also felt to be secondary to influenza A.

This 49-year-old male, two years post cardiac transplantation, is chronically immunosuppressed with cylosporin and prednisone. He presented with a one week history of malaise, headache, coryza, nonproductive cough, fever and myalgias. Several members of his family had recently experienced a similar illness. However, in addition, the patient complained of dyspnea and wheezing.

Examination revealed a temperature of 102°F, pulse of 100 beats per minute and injected sclera and bibasilar crackles in the lungs. Chest x-ray revealed bibasilar interstitial and alveolar infiltrates. Arterial blood gases showed mild hypoxemia (pO2 58 torr). A CBC showed a WBC count of 9.8 with a normal differential count. Patient was begun on amantadine and erythromycin, and immediately underwent transbronchial biopsy and pulmonary lavage to rule out opportunistic infection. All cultures and biopsies proved negative and erythromycin was discontinued. Additionally, a cardiac biopsy was negative for rejection, and right heart catheterization revealed normal hemodynamics. The patient's symptoms rapidly resolved and his lungs cleared.

The pneumonia cannot be proven secondary to influenza A, but the typical clinical presentation, illness in other family members, and lack of evidence for other etiologies, strongly support influenza A as the most likely cause. We do not routinely vaccinate our transplant recipients because of anecdotal reports that influenza A vaccine has precipitated acute cardiac rejection. It is likely we will continue to see this complication until the issue of immunization and rejection is resolved. ◀

Sincerely,
David K. Murdock, M.D.
Christine E. Lawless, M.D.
Eileen Collins, M.S.N., R.N.
Hines V.A. Hospital
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OBITUARIES

***Atkinson, Willis H.,** Bloomington, died November 9, 1986 at the age of 80. Dr. Atkinson was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

****Barancik, Henry,** Bal Harbour, Florida, died November 8, 1986 at the age of 95. Dr. Barancik was a 1914 graduate of Northwestern University Medical School, Chicago.

Blumstein, Robert W., Elk Grove Village, died October 8, 1986 at the age of 47. Dr. Blumstein was a 1964 graduate of the University of Health Sciences/Chicago Medical School.

Bruehsel, Ilse E., Warsaw, died September 27, 1986 at the age of 69. Dr. Bruehsel was a 1944 graduate of the Medizinische Fakultat der Universitat Koln, Koln, Nordrhein-Westfalen, Germany.

Cannon, Paul R., Yorkville, died September 7, 1986 at the age of 94. Dr. Cannon was a 1926 graduate of Rush Medical College, Chicago.

Cavaness, John D., Eldorado, died November 17, 1986 at the age of 61. Dr. Cavaness was a 1951 graduate of the Washington University School of Medicine, St. Louis.

****Deutsch, Ella E.,** Chicago, died November 5, 1986 at the age of 88. Dr. Deutsch was a 1925 graduate of the Fak der Universitat Wien, Wien, Austria.

***Durham, James R.,** Mendota, died October 31, 1986 at the age of 62. Dr. Durham was a 1952 graduate of the Yale University School of Medicine, New Haven, Connecticut.

***Galston, Bernard K.,** Northbrook, died November 25, 1986 at the age of 65. Dr. Galston was a 1945 graduate of the University of Health Sciences/Chicago Medical School.

***Gregorski, Robert F.,** Pekin, died November 6, 1986 at the age of 47. Dr. Gregorski was a 1964 graduate of the Medical College of Wisconsin, Milwaukee.

****Haik, Samuel,** Chicago, died November 2, 1986 at the age of 84. Dr. Haik was a 1931 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Johnson, Carl T.,** Moline, died October 30, 1986 at the age of 73. Dr. Johnson was a 1941 graduate of Northwestern University Medical School, Chicago.

****Kiefer, Joseph H.,** Glenview, died November 6, 1986 at the age of 76. Dr. Kiefer was a 1935 graduate of Northwestern University Medical School, Chicago.

****Lash, Abraham F.,** Palm Springs, California, died November 5, 1986 at the age of 87. Dr. Lash was a 1922 graduate of Rush Medical College, Chicago.

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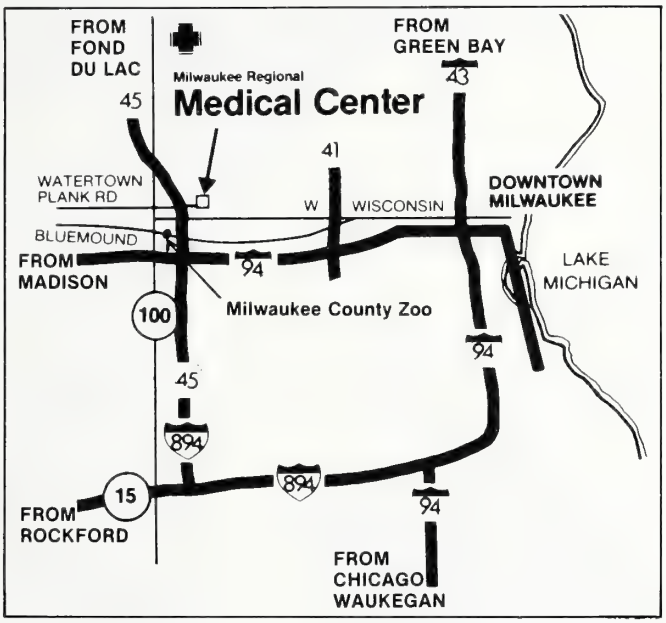
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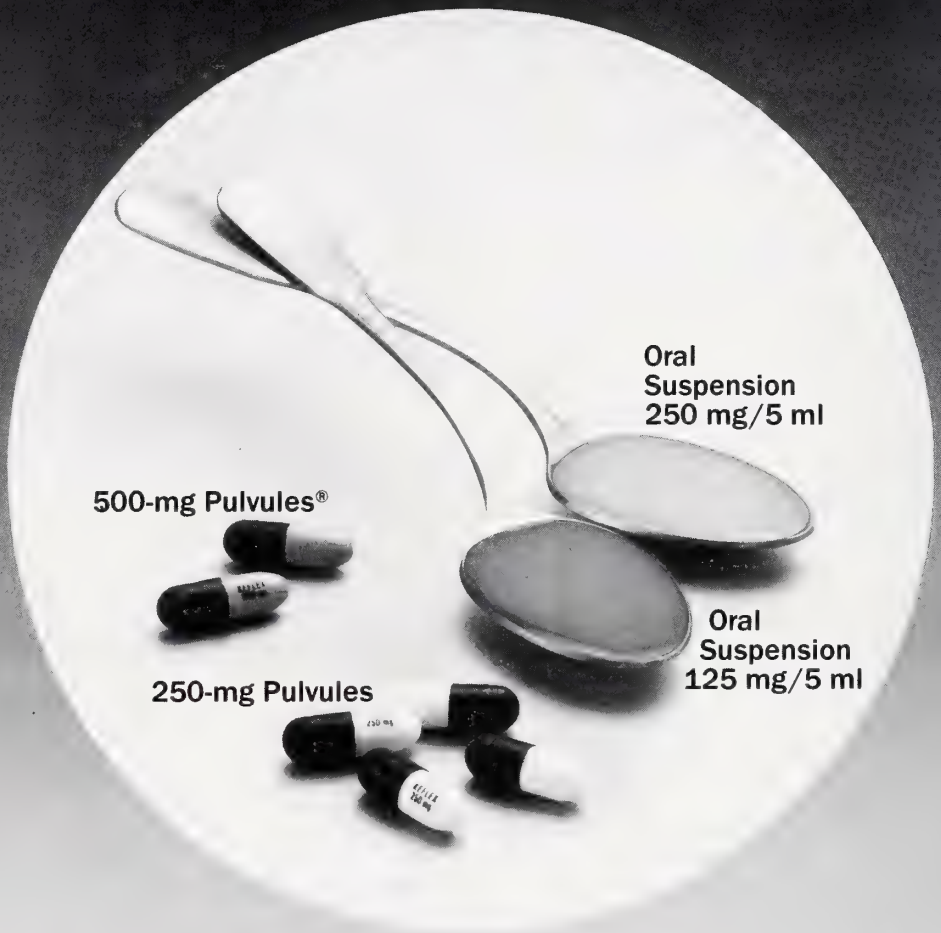
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Coping with the Stress of Malpractice Litigation

By Jeffrey R. Wilbert, Ph.D., Sara C. Charles, M.D., Richard B. Warnecke, Ph.D., and Richard Lichtenberg/Dayton, Ohio and Chicago

Surveys of one thousand randomly-selected Chicago Medical Society members were reviewed. More recent interviews of 80 sued and non-sued physicians chosen from this group revealed a number of newly-sued doctors. Although the method of obtaining data in the studies differed, some comparisons of pre- and post-litigation experiences, coping methods and adaptations are presented.

The practice of medicine is replete with daily stresses uncommon to other professions. Physicians must deal with pain and suffering, problem patients, intense interpersonal relationships and unrealistic expectations.[1] Maladaptive coping strategies can lead to increased distress and decreased ability to effectively deliver medical care.[2,3] Even physicians who cope adequately with daily stresses often report dissatisfaction with many aspects of their work.[4]

In recent years, physicians have witnessed a tremendous increase in malpractice litigation.[5] Our research group has studied the personal and professional impact of medical malpractice litigation on physicians practicing in the Chicago metropolitan area.[6,7] Methods included two mail surveys and a recently completed interview study of both sued and non-sued physicians.[8] These studies have shown that being sued is a significant life stress for most physicians. Physicians typically react to litigation by changing aspects of their professional practice (*e.g.*, practicing defensively) and developing temporary emotional symptoms, such as depression and anxiety.

Although these studies have generated a composite picture of the average physician's reaction to being sued, more can be learned by studying physicians individually. During our interview study, we discovered four recently-sued physicians who, when surveyed by mail one year before, had not been involved in litigation.

It is difficult to contrast directly data obtained from a mail survey with a face-to-face interview. Some authors have discussed the propensity to give more socially desirable responses in a face-to-face format.[9,10] However, some global comparisons are possible.

Because of the confidential nature of the interviews, the identities of the doctors discussed below have been disguised. Their average age was 38, and a total of seven suits (four dropped, three in discovery) had been filed against them at the time of the interview. This paper attempts to generate hypotheses about the interaction of litigation, coping, and adaptation. It provides a glimpse into the thoughts, feelings, and behaviors displayed by these four physicians dealing with the stress of litigation.

Four Illustrations

Prior to being sued, Dr. A was feeling the effects of the threat of litigation in his medical practice and personal life. In the mail survey, he reported that he routinely ordered extra tests, kept careful records, and worked longer hours out of concern about lawsuits. Dr. A also had stated that he was somewhat depressed, anxious, and frustrated by the current malpractice climate, and, in fact, planning early retirement.

By the time he was interviewed, Dr. A had been sued more than once. He characterized his experiences as very annoying and humili-

ating, and said he took them as personal affronts to his competency. Surprisingly, Dr. A reported less apparent symptoms at the time of his interview. He reported only transient dysphoria, anger, and frustration. His experience seemed to have been marked more by anticipatory anxiety than by emotional distress at the time he was sued. He felt "okay now," but could not anticipate his reaction if called to trial. There had been no change from the pre-litigation cautiousness in his practice. Generally, he said that litigation resulted only in a "slightly higher level of stress," and that he did not think about it a lot.

His experience seemed to have been marked more by anticipatory anxiety than by emotional distress at the time he was sued.

Dr. A displayed several coping strategies that seemed to enable him to weather the stress of being sued. His level of insight was good, and he was able to look at himself objectively. Dr. A stated that he would seek outside consultation if he felt seriously stressed. In the meantime, he shared his reactions to ordinary stress in his practice with other doctors rather than his spouse and family. When sued, he discussed his reactions with his peers and office staff, who were extremely supportive. It was also clear that Dr. A had found a way to intellectually distance himself from worrying about litigation. He was able to state confidently, "I practice the best medicine I know how. If I get sued, I get sued." Another coping device for Dr. A was his active pursuit of leisure-time distractions. These were usually planned in advance.

Dr. A was described by his interviewer as open, talkative, and self-assured; he showed a wide range of appropriate affect. His behavior during the interview suggested a well-adjusted man who was well-suited to his work.

Second Illustration

Prior to being sued, Dr. B felt strongly that the threat of litigation had very little impact on his medical practice. He denied ordering unnecessary tests and firmly reported that he had no plans to retire prematurely. In response to the threat of litigation, however, he had begun to keep more meticulous records. Dr. B indicated no symptomatology before being sued. Generally, he gave the impression that the litigation climate had had little or no impact on his personal or professional life.

At the time of his interview, Dr. B's outlook had changed considerably. He characterized being sued as "an embittering experience" and admitted that litigation had affected the way he practiced. He had developed a "sense of negativity toward patients" that he found difficult to resolve. Dr. B reported that he had begun to spend more time with patients who had adverse outcomes and was more detailed in his explanations of possible complications to medical procedures. He denied, however, ordering unnecessary tests, changing his method of record-keeping or over-utilizing consultants in a defensive manner. Emotionally, Dr. B had been depressed, angry, and frustrated for over two weeks, and had also experienced insomnia as a result of being sued. Dr. B also showed signs of decreasing satisfaction with the practice of medicine and said that if he had it to do over again, he would not pursue medicine as a career. His dissatisfaction primarily stemmed from extrinsic factors, such as governmental regulations.

Dr. B's behavior during the interview reflected his lingering hostility and dysphoria. He described few outside interests and viewed his family as his main source of support. He regularly discussed his medical practice and litigation experiences with his peers. Dr. B listed the most stressful aspect of his practice as dealing with consultants. This may suggest that Dr. B's peer relationships were not as reassuring a source of support and counsel as he would have wished. He was described as a controlling man who was guarded and emotionally non-expressive in responding to questions. Generally, Dr. B was considered to be experiencing a considerable level of stress in both his personal and professional life.

A Third Example

Before being sued, Dr. C reported that his professional reactions to the threat of litigation had been limited to more careful record-keeping and increased participation in continuing education courses. The threat of litigation had not engendered any emotional difficulties. He commented that, "I have never even come close to being sued."

After having been sued, however, Dr. C reported that he had begun to "overly explain things" to patients, with a witness present if possible. He also made some further changes in his record-keeping.

He was able to state confidently, "I practice the best medicine I know how."

He described his "frantic" and furious reaction when he learned of the suit; he reported that he immediately obtained a copy of the patient's chart and undertook a thorough review of the details of the case. His efforts were later successful in his defense. Dr. C experienced transient dysphoria, anxiety and sleeplessness.

Dr. C experienced transient dysphoria, anxiety and sleeplessness.

An important aspect of Dr. C's style of coping with litigation was his degree of openness about the experience. He stated that his spouse was the main source of emotional support in dealing with the ordinary stress of his medical practice. However, when he was sued, he shared his reactions with peers, office staff and "anyone who would listen." Dr. C displayed a good level of self-awareness. He stated that he would ordinarily attack problems directly. He reported that he effectively denied those things he could not control. Dr. C also related numerous leisure pursuits. He was described as a friendly, confident, aggressive man who typically confronts problems directly. He utilized direct discharge of his emotions rather than "bottling up."

A Final Example

Dr. D's survey responses before being sued suggested a hypervigilant man doing everything he could to protect himself against litigation. He reported ordering extra tests, keeping more careful records, and thinking about retiring early. Dr. D also reported discouraging his children from pursuing medicine as a career. Even prior to being sued, Dr. D indicated a level of distress marked by transient depression, anxiety, and frustration.

By the time of his interview, Dr. D had been sued more than once. Clearly, he reacted severely to the suits; he reported the latest suit to be the most stressful period in his life. His attitude, indicating a helpless posture, was that, "Anybody can sue anybody for anything at any time." The suits had increased his defensive practices, and he had discontinued some high risk procedures. Dr. D reported "looking over my shoulder" whenever seeing a patient. Dr. D's reaction to being sued was marked by depression, anxiety, anger, and insomnia continuing more than two weeks. He was particularly embarrassed by the suits and listed one of his main worries as neighbors' opinions if they found out. Dr. D reported that, prior to being sued, malpractice was not on his mind much, but that being sued had had profound effects on his attitudes, feelings, and behaviors.

Dr. D seemed to be a man who was considerably burdened by the stress of being sued. He acknowledged that greater contact with peers would have helped him deal more effectively with litigation, although he reported that he had discussed it with them as well as with his spouse. In an attempt to cope, Dr. D reported "diverting" his attention by trying not to take his work home with him, but nevertheless he described worrying excessively about his patients. Dr. D admitted that he needed help in dealing more effectively with stress in general before it took its toll on his physical as well as mental health.

Dr. D admitted that he needed help in dealing more effectively with stress in general before it took its toll on his physical as well as mental health.

Discussion

Each physician reacted differently to being sued; some faired better than others. Although it is difficult to draw general conclusions from individual histories, hypotheses about the effectiveness of various strategies can be offered.

A physician who is ill-equipped to deal with other life stresses will probably have difficulty if faced with a malpractice suit. A physician's personality style, meaning his or her characteristic modes of defensive functioning, will face a formidable challenge when handed a subpoena. Insight into one's psychological functioning is invaluable; a doctor who openly admits to and talks about distressing feelings will find him/herself at an advantage, as will the physician who actively seeks the advice and support of others.[11] McCue[1] advocates open discussion of psychological difficulties by physicians in order to identify maladaptive behavior and avoid excessive emotional distancing from patients. Physicians who are able to share their distress with others will likely find themselves feeling less isolated as a case drags on. Solo practitioners may be handicapped in this regard if the support of peers is not readily accessible.[4]

Physicians who successfully cope with litigation seem to have distanced themselves intellectually and do not perceive a suit as a personal attack. It can be helpful to espouse a firm belief that litigation is simply a part of medicine today and not a commentary on the defendant's competence. This attitude, however, often conflicts with the subject's genuine feelings about the profession. Any doctor's doubts about his/her clinical abilities will be exacerbated by the personally assaultive wording of most malpractice

charges. Successfully-coping physicians often use denial and suppression effectively when more active coping strategies are not available.

Limited medical education regarding the realities of medical practice can lead to coping difficulties in later years. This is illustrated by one doctor's statement: "When I got sued I'd only been practicing about two years, and I thought, what have I gotten into here?" Most medical students and many residents know very little about the business and legal aspects of medicine. Many enter medical practice with idealistic expectations which can be quickly dispelled by a malpractice suit.

A physician who is ill-equipped to deal with other life stresses will probably have difficulty if faced with a malpractice suit.

Complicating the lack of knowledge about the actual stresses of practice among young physicians is the phenomenon described by McCue[12] as "delayed maturation." This refers to the unavoidable fact that many students and residents focus so intensely on their vocational identity as to neglect development of crucial skills and competencies of adulthood. Medical educators would be wise to enhance training in the legal aspects of medicine, and also to attend more to positive emotional development. For example, the beneficial effects of process groups for residents have been documented.[13]

An effective coping device for many physicians is a full leisure life. Physicians who actively plan leisure time and make sure it is not infringed upon by professional responsibilities will likely have a buffer during stressful periods. Hobbies external to medicine can be a refreshing means to relieve professional pressure in an adaptive manner.[14]

Finally, it may be that physicians who take an active approach to dealing with a malpractice suit show better adjustment. Doctors, many of whom are obsessive, controlling people,[15] are prone to feelings of helplessness and depression when involved with the legal system. Physicians who take an assertive stance and feel that they are doing something to help themselves are less likely to feel as vulnerable to self doubt and may be better able to maintain a sense of self-mastery.

Hobbies external to medicine can be a refreshing means to relieve professional pressure in an adaptive manner.

Conclusion

These four physicians illustrate a variety of reactions to both the threat and actuality of being sued for medical malpractice. In the relatively short time of one year, they tended to have more than one suit filed against them. Whether or not they initiated defensive measures prior to the suit, all made some professional adjustments in their medical practices following litigation. All four doctors also acknowledge at least transitional emotional reactions.

Coping mechanisms enable more satisfactory restoration of emotional equilibrium. These include anticipation of litigation, an openness toward one's feelings, active pursuit of social support, developing an intellectual attitude about the litigation crisis, effective use of denial, better organization of one's time enabling leisure pursuits, and an "active" approach to the case itself. Additional study of physicians and their responses to stress may provide more definite conclusions about the interaction of personality style, coping strategies, and adaptation. Such research would seek to restore distressed physicians to more satisfactory and effective personal and professional functioning, and ultimately ensure optimal quality patient care. ◀

Acknowledgement

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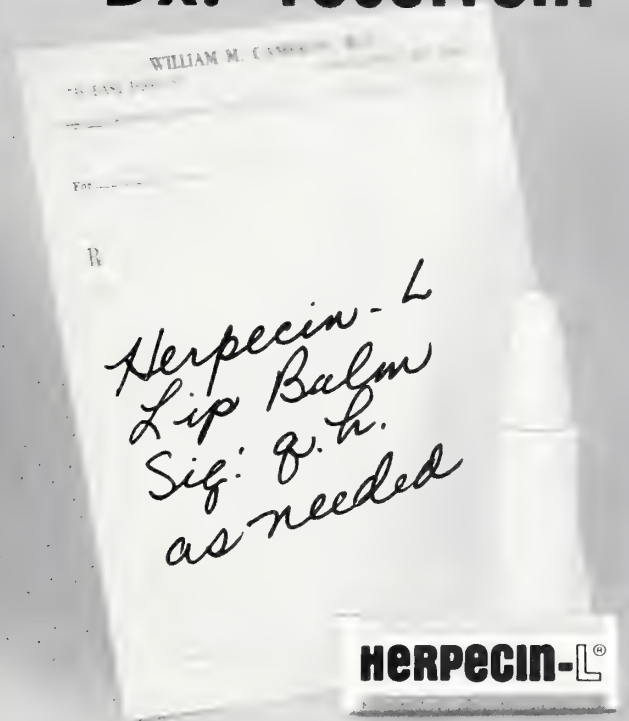
Jeffrey R. Wilbert, Ph.D., is a post-doctoral resident in clinical psychology affiliated with Wright State University, Dayton, Ohio. Dr. Wilbert is a member of the Ohio Psychological Association and an associate member of the American Psychological Association.

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Intracoronary Streptokinase and Fatal Cerebellar Hemorrhage

By Philip B. Gorelick, M.D., Mahesh Parikh, M.D., and Larry McDonald, M.D./Chicago

A 63-year-old black woman had a fatal cerebellar hemorrhage following treatment for acute myocardial infarction. Within 24 hours of treatment with intracoronary streptokinase followed by systemic heparin, she became obtunded, suffered respiratory arrest and lapsed into a coma. In the hours before hemorrhage, marked hypertension and partial thromboplastin times in excess of 149 seconds were recorded. Autopsy demonstrated cerebellar hemorrhage without evidence of underlying disease. Major brain hemorrhage following streptokinase therapy has been infrequently reported. Pathophysiologic mechanisms and suggested guidelines for avoiding such complications are reviewed.

Streptokinase is a thrombolytic agent effective in reperfusing coronary circulation obstructed by thrombus during the early phases of myocardial infarction.[1-25] In properly selected patients, the risk of major bleeding complications is low.[4-25] Serious hemorrhage remains a potential hazard, however, as streptokinase, a plasminogen activator, prevents hemostatic plug formation and facilitates dissolution of thrombus.[1-3] We describe a fatal cerebellar hemorrhage following intracoronary streptokinase administration. Pathophysiologic mechanisms and suggested guidelines for avoiding such complications are reviewed.

Case Report

A 63-year-old black woman was admitted to the emergency ward after awakening with left precordial chest pain, shortness of breath, sweating and nausea. She had a past history of diabetes mellitus, hypertension, myocardial infarction, right hemispheric stroke and diabetic retinopathy with blindness. She did not smoke cigarettes and drank alcohol infrequently. Her medications included furosemide, alpha methyldopa, tolbutamide, and potassium supplementation.

Examination revealed an obese woman with a blood pressure of 140/100mmHg and a pulse rate of 82 beats per minute. The PMI was displaced two centimeters lateral to the midclavicular line in the left sixth intercostal space. An S_4 heart sound was present. There was no cardiac thrill, murmur, jugular venous distention or carotid bruit. There were bibasilar rales. The abdomen and extremities were normal. Neurologic examination was normal except for midposition pupils that were unreactive to light, optic atrophy, and severe diabetic retinopathy.

Electrocardiography revealed QS waves in leads V_1-V_5 and four millimeter ST segment elevation in leads V_2-V_5. CPK was 230 international units (IU), and the CK-MB fraction was elevated. Serum glucose was 307mg/dl, creatinine 1.7mg/dl and BUN 24mg/dl. Complete blood count, platelet count, PT, PTT, and serum electrolytes were normal. Chest x-ray demonstrated cardiomegaly.

In the emergency ward the patient's chest pain was relieved by sublingual nitroglycerin. She was

transferred to the cardiac catheterization laboratory, and coronary arteriography by the Judkin technique was performed. There was 50% stenosis of the right main coronary artery and 100% stenosis of the midportion of the left anterior descending artery (LAD). Next, 270,000 IU of streptokinase were administered by intracoronary infusion. Following this, repeat coronary arteriography demonstrated 80% stenosis of the LAD in its midportion, and diffuse distal vessel disease. Coronary angioplasty was attempted but was unsuccessful as bradycardia and systemic hypotension intervened. The patient was stabilized by cardiac pacing and metaraminol bitartrate administration. She was transferred to the cardiac care unit where intravenous heparin was administered and metaraminol bitartrate was discontinued. Repeat neurological examination showed no change from the initial examination.

The patient remained alert and cooperative during the ensuing hours. However, her blood pressure was poorly controlled and rose as high as 188/150mmHg. Partial thromboplastin times were greater than 149 seconds (control value equal to 30 seconds) and the fibrinogen levels ranged from 1 to 88mg/dl.

Several hours later, the patient suddenly became obtunded and had a respiratory arrest. Neurological examination revealed no response to verbal or noxious stimulation, flaccid quadriplegia, absent deep tendon reflexes, pinpoint pupils, and absent oculocephalic reflexes. Emergency computed tomography of the head demonstrated a large cerebellar hemorrhage with subarachnoid extension, dilation of the lateral and third ventricles, and obliteration of the fourth ventricle. The patient was treated with mannitol and dexamethasone, but continued to deteriorate, and died on the following day.

Selected Necropsy Findings

The heart weighed 725 grams. The thickness of the right ventricle was 0.6cm and the left 1.9cm. The circumference of the tricuspid valve was 12.5cm, pulmonic valve 9.0cm, mitral valve 10.5cm and aortic valve 7.0 cm. The anterior epicardial surface was bulging and hemorrhagic. The right and left atria were enlarged, and no mural thrombi were present. The foramen ovale was not patent, and the coronary sinus was normal. The tricuspid and pulmonic valves were thin and transparent. The mitral and aortic valves were normal. The right ventricle was hypertrophied, and the hypertrophic left ventricle was dilated to approximately 2.5 times its expected volume. An aneurysm measuring $8 \times 6 \times 1.5$cm was noted on the left anterior ventricular wall. The cut surface of the left ventricle revealed a hemorrhagic transmural infarction of the anterior wall, anterior septum and apex. The LAD was narrowed and partially obstructed by a hemorrhagic plaque located 3.5cm distal to its orifice. Mild atherosclerosis was noted in the left circumflex and right main coronary arteries. Microscopic examination of the LAD demonstrated a small mural thrombus and recent hemorrhage into the atheromatous plaque with almost complete obstruction of the lumen.

The formalin-fixed brain weighed 1250 grams. The leptomeninges were diffusely stained by blood. The proximal basilar artery was completely obstructed by atheromatous plaque. A blood clot extruded from the anterior aspect of the left cerebellar hemisphere. Coronal sections of the cerebellum revealed hemorrhage measuring $3 \times 2 \times 2$cm. The medulla oblongata was compressed and there was herniation of the cerebellar tonsils and brainstem. Microscopic examination of the cerebellum revealed recent hemorrhage. There was no evidence of underlying cerebellar infarction, aneurysm, tumor or arteriovenous malformation. Coronal sections of the cerebrum appeared dusky, and there was a slit-like cavity measuring 0.8cm extending from the right putamen to the right anterior limb of the internal capsule, which represented an old lacunar infarction.

Comment

Streptokinase is a fibrinolytic agent which promotes conversion of the proenzyme plasminogen to plasmin. Once plasmin is generated, it may affect hemostatic plug formation by several mechanisms:[1-3,26] (1) digestion of fibrinogen which reduces the likelihood of plug formation, (2) creation of fibrinogen degradation products which may alter plug formation by impairing conversion of the remaining fibrinogen by thrombin and subsequent polymerization of fibrin monomers, and (3) disruption of the hemostatic plug by lysing fibrin before the plug becomes organized. This sequence of events, responsible for the therapeutic thrombolytic effects following streptokinase administration, also predisposes to bleeding complications. The major determinant of bleeding, however, is underlying tissue damage. When bleeding complications arise, they occur typically at sites of trauma (*e.g.*, venipuncture, mucosal surfaces) or sites related to underlying vascular disease (*e.g.*, myocardial or cerebral ischemia).[26-31] Although laboratory measurements of fibrinolytic activity substantiate the presence or absence of such activity, they do not correlate with the incidence or severity of bleeding.[32]

Intracranial hemorrhage following streptokinase therapy is uncommon. Aldrich[33] and colleagues reviewed the frequency of cerebrovascular complications in aggregate data from 15 streptokinase studies encompassing 1,996 subjects, and found a 0.7% frequency of brain hemorrhage. In their own series of 91 patients,[33] a 4% frequency of intracranial bleeding was encountered. We reviewed data from 17 coronary reperfusion studies[4,5,7,8,10-13,15,16,18,19,21-25] in order to determine the frequency of *fatal* intracranial hemorrhage following streptokinase infusion. We found cerebral bleeding as the cause of death in only three out of approximately 1700 patients (0.002%). A 0.6% mortality due to intracranial bleeding was reported in similar trials conducted in 600 patients with chronic peripheral arterial disease.[34] Differences in the frequency of fatal intracranial hemorrhage in coronary and peripheral artery reperfusion studies may be explained in part by variation in total dosages and routes of administration of the thrombolytic agent, and

variation in the use of anticoagulant agents from trial to trial.

In our patient, hemorrhagic complications were noted in both the heart and brain at necropsy. It is not surprising that the heart was a major focus of bleeding complications, as there was clinical evidence of acute myocardial tissue damage. At the time of streptokinase infusion, however, our patient did not seem to be at particularly high risk for intracranial bleeding. Although she had suffered a stroke several years before and was hypertensive, there were no major central nervous system contraindications to thrombolytic therapy.

We propose that the sequence of events following streptokinase infusion predisposed our patient to brain hemorrhage. Systemic hypotension complicated the unsuccessful coronary angioplasty operation, and may have led to temporary brain ischemia or subclinical infarction. In our patient, the cerebellar borderzone or watershed regions may have been particularly susceptible to ischemia. This was because the proximal basilar artery was completely occluded by atheromatous plaque, diminishing potential routes for collateral blood supply to this region. The lack of necropsy confirmation does not necessarily exclude a diagnosis of cerebellar infarction, however, as the massive brain hemorrhage may have obliterated evidence of residual ischemic tissue damage. Additionally, our patient's postprocedural course was complicated by severe arterial hypertension following the administration of metaraminol bitartrate. In the presence of uncontrolled hypertension, the use of fibrinolytic agents is contraindicated[35] as the risk of bleeding is thought to be heightened significantly.[35,36]

The concurrent administration of heparin must also be considered in the pathogenesis of our patient's intracranial bleeding complication. Commercially available heparin preparations are heterogeneous, polycomponent drugs capable of multiple interactions including anticoagulant and antithrombotic activities.[37] Risk factors predisposing patients to bleeding during heparin administration include age and sex (elderly females), underlying hemostatic defects, postoperative or post-traumatic states, concurrent administration of aspirin, serious concurrent illness and history of heavy alcohol consumption.[38,39] Patients who are receiving heparin therapy require judicious control of blood pressure and careful monitoring of partial thromboplastin times to reduce the risk of bleeding complications.[40-43] In our patient, neither blood pressure nor bleeding parameters were judiciously controlled in the period following streptokinase administration.

There is an estimated 1% incidence of cerebral hemorrhage associated with thrombolytic therapy and a 0.5% incidence observed with heparin.[36] Cerebral bleeding complications following thrombolytic therapy may be avoided by exercising good clinical judgement in appropriate case selection and management.[1,33,36,44] Patients with recent (within two months) stroke, other active intracranial disease,[36] recent TIA,[33] or severe arterial hypertension[35] should not be considered candidates for thrombolytic therapy. Patients with high likelihood of left heart thrombus or other cardiac sources of emboli, hemostatic defects, or those who are over 75 years of age, should be considered at greater risk for bleeding complications and monitored carefully. Prior to, during, and after thrombolytic therapy, care should be taken to prevent marked elevations or drops in arterial blood pressure. Heparin therapy, if instituted, should be administered and controlled according to standard procedures.[36] In addition, serial neurological examinations during the postprocedural period may help detect intracranial bleeding.[45]

Streptokinase is not an ideal agent for emergency clot lysis because it is antigenic, has a relatively long half-life and low specificity for fibrin, and induces a generalized lytic state.[46] A newly-developing class of thrombolytic agents, of which "tissue-type plasminogen activator" is a member, has the potential to overcome these disadvantages. By converting plasminogen to plasmin primarily after binding to the fibrin clot, such "fibrin-specific" agents are less likely to cause bleeding. Although these agents possess theoretical advantages, prospective clinical trials are needed. These will determine whether fibrin specific agents possess the dissolving effect on the hemostatic plug, incur a lower incidence of distal bleeding complications, and overcome the hazard of reperfusion hemorrhage following regional therapy for acute coronary or cerebral artery thrombosis.[35] If these complications can be minimized, the agents promise to be a welcome addition to our treatment armanentarium for acute clot lysis in coronary and cerebral circulations. ◀

Acknowledgement

We thank Ben Fisher, M.D., Robert M. Crowell, M.D., and Louis R. Caplan, M.D. for reviewing this manuscript.

References

A complete list of references to "Intracoronary Streptokinase and Fatal Cerebellar Hemorrhage" may be obtained by writing the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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A Consideration in Evaluation of Short Stature

Cohen Syndrome

By W. Patrick Zeller, M.D., Dennis Rademaker, D.O., Dorothy Kent, M.S.N., Peter Hasiakos, D.D.S., and Paul Wong, M.D./Maywood and Chicago

Cohen syndrome, characterized by hypotonia, obesity, mental deficiency, and facial, oral, ocular and limb anomalies, should be considered in the differential diagnosis of short stature. Dysmorphic features may be variable and should be viewed with suspicion. Diagnosis utilizes patient history and anthropometric physical exam without specific laboratory testing. This case of Cohen syndrome and review of the literature illustrates variation in dysmorphism and emphasizes the importance of dysmorphic facies in an approach to short stature.

In 1973, Cohen *et al.*,[1] first reported a newly-recognized syndrome, consisting of craniofacial, hand, foot and oral anomalies. Obesity with onset in mid-childhood, hypotonia and mental deficiency were characteristics cited.

In 1978[2] Carey and Hall further delineated Cohen syndrome, listing mental retardation as a variable feature. Recently, other reviews[3-5] have further investigated the broad spectrum of malformations associated with this syndrome. This paper reports a patient whose features are consistent with Cohen syndrome. The patient was referred by a dentist for dental anomalies, course facies and short stature.

Case Report

An 18-year-old male was evaluated for short stature, obesity and dental abnormalities. He was born, at term, to a 38-year-old gravida 3 para 2 mother by normal vaginal delivery. Birthweight was 3835 grams. Prenatal course was unremarkable, without illness or drug ingestion. The patient had severe feeding problems and frequent vomiting in early infancy. Early development was delayed, with late achievement of major milestones. Eight supernumerary impacted teeth were removed at age 15. Family history was unremarkable and parents were not related. The patient's school performance was adequate and he had graduated from an inner city high school. Obesity had been evident in early childhood and truncal obesity was observed later. Short stature was evident from age 15. (Figure 1)

Physical exam revealed an 18-year-old short male with truncal obesity. He was normocephalic with normal anthropometric measurements. Palpebral fissures were downslanting. There was a prominent nasal bridge, micrognathia, and a short philtrum. In addition, the ears were protuberant and the eyebrows crossed in the midline. (Figure 2) Full ophthalmologic examination was normal. The palate was high-arched and dental examination showed crowding. (Figure 3) The supernumerary teeth[6] had been removed. Thyroid was normal in size and consistency. Extremities revealed small hands (10%) and feet (10%), but no evidence of tapering of the digits. Hyperextension of the first proximal interphalangeal joints and genu valgum were present and mild hypotonia was evident. Neurologic examination was otherwise normal. There was kyphoscoliosis and lumbar lordosis. External genitalia were normal male Tanner Stage 5.

Laboratory studies included normal chromosomes, thyroid functions and oral glucose tolerance. Radiologic studies of hands and bone age were normal. No endocri-

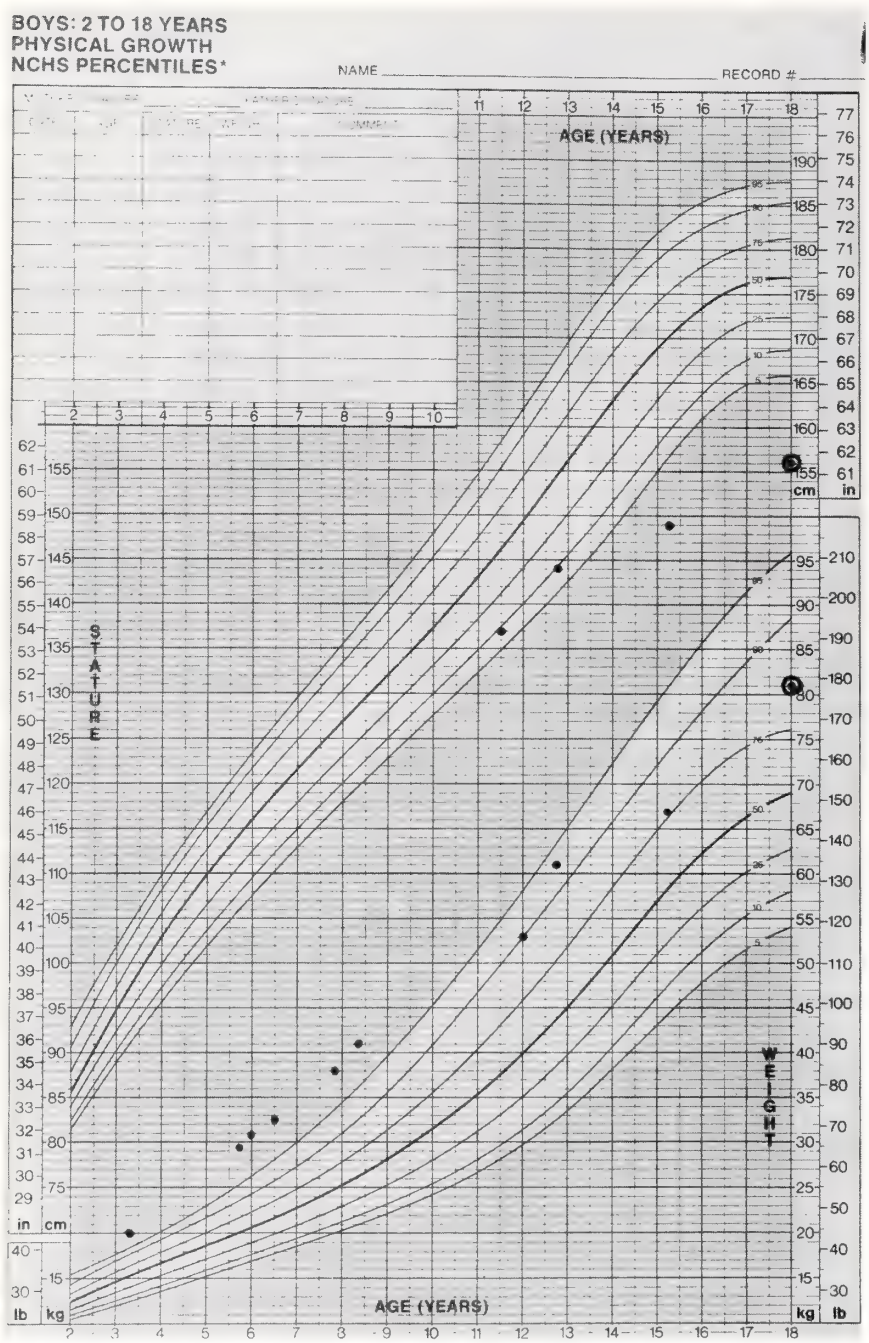


Figure 1
Growth Curve © 1982 Ross Laboratories.
Reprinted with permission of Ross Laboratories, Columbus, Ohio 43216. Adapted from: Hamill, P.V.V., Drizd, T.A., Johnson, C.L., Reed, R.B., Roche, A.F., Moore, W.M.: "Physical Growth: National Center for Health Statistics Percentiles," Am J Clin Nutr *32:607-629, 1979. Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland.*

nologic cause of short stature was found.

Discussion

Dysmorphic syndromes like Laurence-Moon-Biedl[7] (obesity, mental deficiency, polydactyly or syndactyly, retinitis pigmentosa and hypogonadism) and Prader-Willi[8] (obesity, mental deficiency, hypotonia and hypogonadism) can be excluded by our patient's physical exam, Tanner Stage 5 genitalia and lack of marked mental deficiency. Klinefelter's syndrome[9] (seminiferous tubular dysgenesis, hypogenitalism, hypogonadism and eunuchoid body habitus) was ruled out by physical exam, Tanner Stage 5 genitalia and normal chromosome study. Carpenter's syndrome,[10] (acrocephaly, polydactyly and syndactyly of the feet, and lateral placement of inner canthi) also was excluded by lack of extremity and head abnormalities in our patient. Frohlich's syndrome (hypothalamic lesions) can be excluded with a normal neurologic exam, normal rate of growth and normal endocrine evaluation.

With these dysmorphic syndromes eliminated, we reviewed reported cases that delineated a broad spectrum of malformations associated with Cohen syndrome. Carey and Hall[2] noted mental retardation with wide variation, but normal intelligence in two cases. In a review of 13 cases, Friedman and Sach[5] reported that 75%-100% of cases had displayed hypotonia, mental retardation, delayed puberty, truncal obesity, narrowing digits of the hands and feet and characteristic craniofacial appearance. The craniofacial abnormalities included high nasal bridge, short philtrum, micrognathia, maxillary and malar hypoplasia, open-mouthed appearance and high arched palate.[11]

Our patient had many of the features described by Cohen, *et al.*, but did not exhibit any of the less-common findings described by Friedman and Sach, such as ophthalmologic abnormalities, syndactyly in the hands, and/or dislocated hip. Our case had some interesting variations. First, the onset of obesity in early childhood was not evident on the growth curve. The onset of truncal obesity was not recorded, but was present at the time of our examination. Other authors,[2,12] likewise, had not recorded the onset of obesity and/or truncal obesity. No other growth curves are available in the literature for comparison. Second, there was a lack of tapering of the digits, which has also been reported[12] in at least three other cases. Third, our patient was not mentally retarded, as in two cases reported by Carey and Hall.

Others should be aware of the variability in symptoms of Cohen



Figure 2
Patient with Cohen syndrome

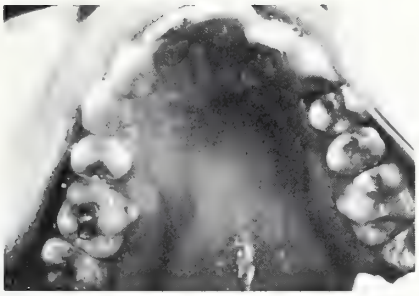


Figure 3
High arched palate

syndrome, and to include it as a possible diagnosis in the evaluation of short stature. Since there are no specific laboratory tests for Cohen syndrome, there may be a tendency to diagnose it only when the typical features are present. Nevertheless, patients with variable features should be documented, since clinically similar conditions may be etiologically dissimilar, and etiologically identical conditions may have phenotypic variation. Detailed recordings of variations combined with constant review of the literature may provide the basis for future etiologic delineation. ◀

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AAMA 30th Annual Convention

By Robin Bluestein, CMA-C/Chicago

The 30th Annual Convention of the American Association of Medical Assistants (AAMA) was held October 16-19, at the Holiday Inn Mart Plaza in Chicago. This year's convention included meetings of the House of Delegates and reference committees, and the installation of this year's national president, Jo Estrada, RN, CMA-AC (Texas). Other officers installed included: Ann M. Jordana, RT, CMA-AC (Florida), vice president; Mary Klinge, RRA, CMA-A (Kansas), secretary/treasurer; A. Christine Payne, RN, CMA-C (Florida) and Myrtle Ingvaldsen, CMA-A (Virginia), trustees for a 2-year term; Barbara Parker, CMA-AC (Washington), finishing out her second year of a 2-year term; Jana McCourey, CMA (Alabama), speaker of the House and Norma Parker, CMA (Nebraska), vice speaker of the House.

A total of 110 delegates convened on Friday, October 17, and acted as described below.

AAMA Bylaws were changed so that Article VI, Section 2, Qualification, now describes active and associate members as follows: *(A) Active: An Active member shall be one of the following: 1. An AAMA-certified medical assistant (CMA); 2. An Active member as of December 31, 1987.*

This means any non-CMA who is now an active member, or any non-CMA who joins by the 1987 deadline, may retain active status by paying full dues. They will have a voice and vote, and be eligible to serve on committees or as delegates.

(C) Associate: An Associate member shall be one who is not eligible for another category of membership but who is interested in the profession of medical assisting.

These members pay full dues and would not be eligible to be an officer, trustee, delegate or committee chairman on a national level. Privileges on a society and chapter level would be determined by those entities. Non-CMAs joining after December 31, 1987 would hold an associate member status until they become certified.

The resolution to support Mothers Against Drunk Driving (MADD) was adopted and all members were encouraged to give their support.

A resolution regarding missing children was adopted; members were encouraged to post pictures in the workplace as appropriate.

As voted by the House of Delegates last year, there will be a House of Delegates meeting in Chicago in 1987 following this year's format. The 1988 AAMA convention will be hosted by the Virginia Society, and will include workshops, seminars and area tours. At this time, it will be determined whether to continue with separate House of Delegates meetings and regional programs on a yearly basis, or return to a week-long national convention.

Information regarding the Illinois Society and/or medical assisting can be obtained from Mary Lou Ostrowski, CMA, president, Illinois Society, 1704 E. Jackson St., Bloomington 61701; Robin Bluestein, CMA-C, co-chairman, public relations committee, 2247 West Estes, #2, Chicago 60645; or Catherine M. Hill, CMA, co-chairman, public relations committee, 900 S. Plum Grove Road, Palatine 60067. ◀

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

GIBSON CITY:
Opportunities for Family Practice and Internal Medicine either in partnership with a family practitioner or in solo practice. Fully equipped office facility and income support arrangements available. Stable farm community serving 20,000 population within a 20 mile radius. 30 miles north of Champaign-Urbana. Three hour drive south of Chicago. Contact: Terry Thompson, Administrator, Gibson Community Hospital, 1120 North Melvin Street, Gibson City 60936, (217) 784-4251. (4)

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St Louis. Average 30 miles from Springfield. Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MOUNT CARMEL:
Orthopedic Surgeon, Pediatrician and Family Practioner—Population 10,000. 64 bed JCAH accredited general hospital, HCA managed, newly built in 1983 replacing a well-established older hospital. Good secondary and high-school and junior college. First year guarantee and other excellent fringe benefits, a lovely river city with several large thriving industries. Any cultural or recreational benefits not provided here are available in nearby large city. Contact: William S. Vokonas, Administrator; Wabash General Hospital, 1418 College Drive, Mt. Carmel, 62863, or phone (618) 262-8621, extension 300. (1)

PEKIN:
Opened new 20-office multi-specialty physician's medical center attached to Pekin Memorial Hospital, a 202-bed progressive community hospital. Competitive income guarantee and relocation allowance available. Contact: Ruth Campbell, Court and 14th Streets, Pekin, 61554. (1)

PITTSFIELD:
Illini Community Hospital. Practice opportunities for FP, OB/GYN, Internist and Pediatrician; solo or partnership. Office space and financial assistance available. Service area 25,000. Excellent outdoor recreation. Close to St. Louis and Springfield. Good school systems, including colleges and universities. Contact: Kathleen Wegener, 640 W. Washington, Pittsfield, 62363. (217) 285-2113. (2)

SYCAMORE:
Internist with subspecialty interest in rheumatology to join a well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, 60178. (1)

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Regional bursitis of the trochanteric, ischiogluteal, iliopectineal, or iliopsoas bursa may cause pelvic girdle pain. In 72 patients with trochanteric bursitis, pain extended from level L-2 to the knee. It has been associated with other pathologies in 91.6% of cases. These include osteoarthritis, rheumatoid arthritis, hip replacement, trauma, leg length discrepancy, and alterations in gait. Rest appears to be the crucial treatment; ultrasound is useful in only a minority of cases. Local injections may be diagnostic as well as therapeutic. (Schapira, D., *et al,: Arch Phys Med Rehab* 67:11, 815-7, 1986)

Children should be screened during the neonatal period for sickle cell disease. Those with this anemia should be treated with oral penicillin prophylactically by age four months to reduce the mortality and morbidity associated with pneumococcal septicemia. Children under age three with sickle cell anemia were randomly assigned to receive either 125mg penicillin V potassium or a placebo twice daily, and were followed for 15 months. The penicillin-treated group showed an 84% decrease in infection incidence when compared to the control group, and no deaths. The 105 placebo-treated children had three infection-related deaths. (Gaston, M., *et al.: N Engl J Med* 314:1593-99, 1986)

Fractures of the femoral shaft which had been treated conservatively in 44 children were assessed by radiography to determine longitudinal bone growth. Overgrowth by approximately 8.1mm had occurred, predominantly in boys. This was not influenced by patient age, type of injury, type or site of fracture, amount of bone fragment overlap or handedness. (Clement, D., Colton, C.: *J Bone and Jt Surg* 68B:4, 534-6, 1986)

A survey of U.S. population revealed that 98% of adults recalled having had a blood pressure test, but only 35% recalled having had a blood cholesterol test. Data presented showed that coronary heart disease mortality rose significantly when the cholesterol level rose above the twentieth percentile. Those with the lowest cholesterol levels showed an increased mortality from cancer, possibly explained by cancer's cholesterol-lowering effect. The increased risk of heart disease from hypertension appears easier to control because of the increased incidence of blood pressure readings compared to the number of serum cholesterol tests performed, and, also, because of medications available for controlling these risks. (Martin, J.: *et al,: The Lancet* 8513:933-6, 1986)

Carotid endarterectomy was evaluated retrospectively in five hospitals. Of 107 procedures in 95 patients, 55% were justified, 32% were questionable and 13% were inappropriate. Serious complications had resulted in 5.6% of cases. The number of procedures performed had increased annually and varied geographically with a ratio of 3.5 from highest to lowest. This study suggests that the procedure be performed at hospitals with a rate of 200 vascular cases, and that patients be more carefully selected, particularly those presenting with hemiparesis or completed occlusions. (Merrick, N., *et al.: JAMA* 256:18, 2531-5, 1986)

Radioimmunoassay of serum chromogranin A in patients with small-cell lung cancer was markedly elevated (815+/−290ng/mL) when compared to normal controls (123+/−6ng/mL) and those with chronic obstructive pulmonary disease (169+/−18ng/mL). Elevated serum chromogranin A levels were seen in 53% of patients with limited disease, and 72% with extensive disease. Patients with lung adenocarcinoma had serum levels 180+/−22ng/mL; those with large cell lung carcinoma 183+/−23ng/mL; and those with epidermoid lung cancer 203+/−37ng/mL. These serum levels appeared to reflect the extent of involvement of small cell lung cancer. (Sobol, R., *et al.: Ann Intern Med* 105:5, 698-700, 1986)

A hypertension detection and follow-up program evaluated the effect of diuretics on serum cholesterol levels in 7,006 patients. The diuretic drug most often used was chlorthalidone, and serum cholesterol levels were determined annually. Cholesterol levels increased significantly within six months to one year on the diuretic, and a gradual return to the base-line cholesterol level occurred within 2-5 years. (Williams, W., *et al.: Am J Prev Med* 2:5, 248-55, 1986)

Sexual activity was studied in male patients who had sustained a cerebrovascular accident at least six months earlier. Patients with right hemisphere involvement noted decreased libido in 67% of cases, while 21% noted this in left hemisphere lesions. Potency was similarly impaired, significantly so in patients with a right hemisphere lesion. Those with a left hemisphere lesion and impaired sexual function had radiologic confirmation or behavioral evidence of an anterior infarct, whereas the right hemisphere lesion patients showed no relationship between sexual impairment and lesion site. (Coslett, H., Heilman, K.: *Arch Neurol* 43:10, 1036-9, 1986) ◂

PHYSICIANS



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A GREAT WAY TO SERVE

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Registration and Education (DRE)

Medical Disciplinary Orders

- *Leo Ariel* (lic. #036-036189)
  Effective October 9, 1986, Dr. Ariel's medical license was suspended.
- *William L. Buhrow* (lic. #036-049918)
  Effective September 29, 1986, Dr. Buhrow's medical license was placed on probation until December 4, 1988.
- *John E. Ellis* (lic. #036-073700)
  On September 19, 1986, Dr. Ellis was granted a medical license which is subject to an 11 month probationary term.
- *Robert H. Kokernot* (lic #036-040234)
  Effective October 16, 1986, Dr. Kokernot's medical license was indefinitely suspended.
- *Edwin Rayner Levine* (lic #036-025773 & 003-036-025773)
  On September 29, 1986, Dr. Levine's medical license was indefinitely suspended and his controlled substance license was revoked for a minimum of five years.
- *Steven M. Lynn* (lic. #036-066010)
  Effective October 16, 1986, Dr. Lynn's medical license was indefinitely suspended.
- *Andrew Miesz* (lic. #036-042820)
  Effective November 21, 1986, Dr. Miesz's medical license was indefinitely suspended for at least one year.
- *Robert C. Robertson* (lic. #036-029852)
  Effective November 21, 1986, Dr. Robertson's medical license was suspended for an indefinite period.
- *Ralph Herbert Roeper* (lic. #036-048924)
  Effective October 9, 1986, Dr. Roeper's medical license was placed on probation for a year and a half, subject to certain conditions.
- *Richard Runstrom* (lic. #036-032271)
  Effective October 19, 1986, Dr. Runstrom's medical license was placed on inactive status and encumbered.
- *Romeo C. Soriano* (lic. #036-047101)
  Effective October 22, 1986, Dr. Soriano's medical license was placed on probation for two years.
- *John C. Wohlrabe* (lic. #036-042154)
  Effective October 22, 1986, Dr. Wohlrabe's medical license was suspended.
- *Charles K. Wolfe* (lic. #036-032014)
  Effective October 9, 1986, Dr. Wolfe's medical license was placed on probation for an indefinite period, but not less than three years.
  (Source: Orders received from the Director of DRE) ◀

From the Department of Public Health (IDPH)

Identification of Organ Donors Among Hospital Patients

At its December 3, 1986 meeting, the IDPH Hospital Licensing Board discussed the new law requiring that hospitals develop procedures for identifying potential organ donors. Since the law does not require IDPH to develop rules for regulating this activity by hospitals, the Board decided to leave the formation of guidelines and procedures to each hospital and the trade and professional associations.
(Source: December 3, 1986 meeting of the Hospital Licensing Board.)

Rules to Designate Trauma Centers

The IDPH Emergency Medical Services Council met on December 4, 1986, to receive a draft of rules to designate trauma centers outside Chicago. Proposed rules will be distributed to interested parties and public hearings will be scheduled for March or April 1987. It is anticipated that the final rules will be adopted in July 1987.

Next summer, IDPH plans to survey hospitals desiring to remain or become designated as trauma centers. The actual designation process is scheduled to begin in January 1988, with final designations made by July 1988.
(Source: December 4, 1986, IDPH Statewide EMS Council meeting.)

Revision in Rules Requiring Tissue Review

The IDPH Hospital Licensing Board is considering revising rules which currently require that hospitals have all tissue/specimens removed at surgery reviewed macroscopically and, if appropriate, microscopically, by a pathologist.

Rules on examination of removed tissue in ambulatory surgical treatment centers are under final revision. The following tissue and materials would be exempt from required review by a pathologist: foreskin, fingernails, toenails and teeth; bone, cartilage, normal skin and scar tissue coincidentally removed during cosmetic or corrective surgery; cataracts removed during eye surgery; and foreign substances, such as wood, glass and pieces of metal, including previously inserted surgical hardware.

(Source: December 3, 1986, meeting of the Hospital Licensing Board.)

Regulation of Physician Office Laboratory Services

The IDPH Clinical Laboratory and Blood Banking Advisory Board has drafted a proposal to regulate laboratory services including those offered by physicians, clinics, HMOs, ambulatory care centers and ambulatory surgical centers.

The draft would require those offering lab services to meet certain quality assurance, physical plant, sanitary, staffing and recordkeeping requirements appropriate to the types of tests offered. This proposal will be developed by IDPH into legislation for the next General Assembly session.

(Source: November 12, 1986 meeting of Clinical Laboratory and Blood Banking Advisory Board.)

Survey on the Availability of Obstetrical Services in Illinois

IDPH, in cooperation with ISMS and other professional associations, is planning to conduct a survey of hospitals, family physicians, general practitioners and obstetrician-gynecologists to determine the extent of obstetrical services available in various parts of Illinois. The survey, to be conducted early 1987, will inquire into factors contributing to the reduction of such services in Illinois.

(Source: December 2, 1986 meeting of Obstetrical Survey Planning Committee.)

Persons interested in obtaining more information on any of the above items are invited to contact the ISMS Division of Educational and Medical Services.

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Figures 2A and B

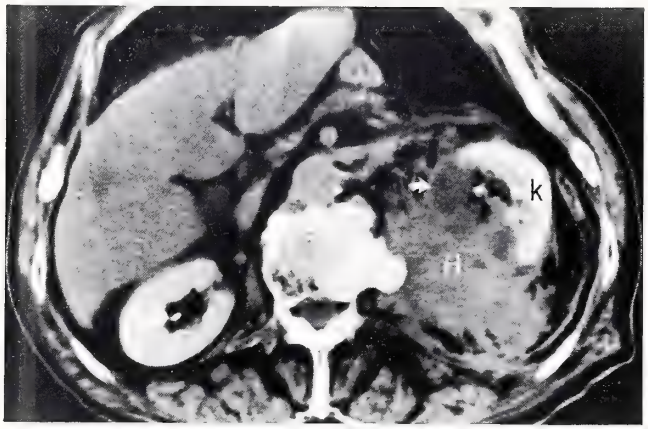


Figure 2A. CT after figures 1A and B. A large hematoma (H) displaces the left kidney (K). A small segment (arrow) of the upper pole nephrogram is absent. Treatment was conservative.

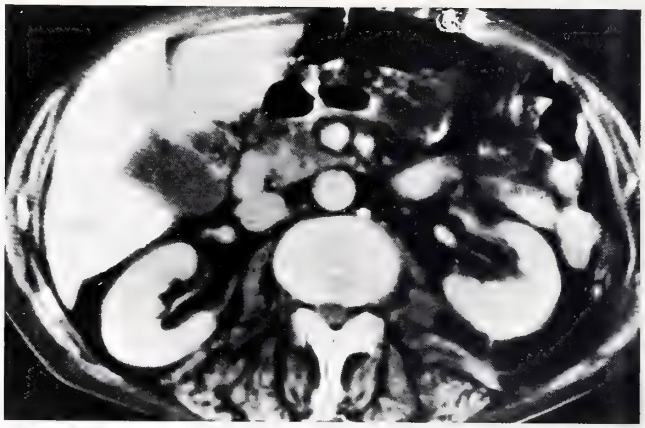


Figure 2B. Contrast enhanced CT nine months later. The hematoma has been resorbed. The left kidney is minimally deformed but otherwise normal.

Viewbox

(Continued from page 6)

Answer: Computed tomography

All of the imaging methods mentioned can provide useful information in patients with renal trauma. Computed tomography, however, has been found to most clearly demonstrate the site and extent of renal damage in the greatest number of patients. (Figures 2A and B)

Renal injury, either isolated, or accompanied by disruption of other intra- or extra-abdominal organs, may occur following blunt or penetrating trauma. The injured patient's vital functions are evaluated first. If the patient is stable and renal injury is suspected, diagnostic studies are performed. Renal injuries are commonly grouped into three categories.

Type I: Minor injuries involve the renal parenchyma, but do not affect the renal collecting system and major vessels. These represent 70%-80% of renal injuries and are managed nonoperatively. Transient microscopic hematuria may be present. In the absence of more serious non-renal injuries, the patient is hemodynamically stable.

Type II: Major injuries involve both the renal parenchyma and the collecting system, with extravasation of urine and, possibly, severe hemorrhage. Representing 10%-15% of renal trauma, management of these injuries is controversial, and may be surgical or nonoperative.

Type III: Catastrophic injuries occur in 5%-10% of patients and include shattered kidneys and renal vascular pedicle disruption. Patients may be hemodynamically unstable, and urgent surgical intervention is frequently required.

In the majority of patients, a normal intravenous urogram (IVU) with nephrotomography excludes severe renal injury. However, information provided by an abnormal IVU is frequently non-specific, and is inaccurate in determining the extent of renal injury in up to one-third of patients.[1-3] Only renal non-opacification or extravasation of contrast material is specific for major injury.

Angiography has traditionally been used to further assess the extent of renal injury in the presence of an abnormal IVU. Disadvantages of this method include the invasive nature of the procedure, potential complications, and the time required to perform the procedure. The advent of rapid, dynamic computed tomographic (CT) evaluation of the abdomen has led to investigation of its role in evaluating renal trauma.

Numerous studies indicate that CT is more specific and somewhat more sensitive than IVU with nephrotomography in the assessment of renal injury. Using contrast enhancement, preferably dynamic scanning, information regarding the functional integrity of the kidneys[4] and acute hemorrhage may be obtained. Extent of injury is clearly defined, as well as localization of hematoma and extravasated urine. A plain film of the abdomen following CT evaluation may be obtained to further assess the ureters.

CT is particularly useful in the diagnosis of renal injury in children. Comparison with sonography and radionuclide imaging has shown CT to be superior in both anatomic definition and contribution to management decisions in children.[5,6]

The role of CT in the assessment of renal vascular pedicle injury in adults is controversial. Two studies have concluded that the information provided by CT examination is sufficiently accurate to replace angiography in the initial assessment of these injuries.[7,8] Conversely, another study indicated false negative CT results with vascular pedicle injuries.[9]

Despite the superior anatomic definition of renal injuries provided by CT, it is not clear that routine use of CT in the assessment of isolated renal trauma is worthwhile. Several studies revealed that the information provided by CT did not significantly alter adult

patient management decisions.[10,11]

Concurrent injury to retroperitoneal organs occurs in 50%-80% of penetrating and 10%-20% of blunt abdominal injuries.[2,3,10,12,13] CT may be used as the initial diagnostic imaging modality in these patients. In these cases, it may be desirable to eliminate the IVU entirely and assess renal injury by using CT alone. IVU prior to CT may detract from CT diagnostic accuracy by decreasing the contrast differential between non-enhanced and enhanced phases of the study, as well as preventing accurate assessment or renal perfusion and function.[4] The additional contrast administered increases the risk of nephrotoxicity. In addition, obtaining two studies requires more time.

CT is superior to other imaging methods in defining renal trauma in children and adults, but the effect on patient management in adults does not warrant routine use of CT in evaluating isolated renal injuries. When imaging of the whole abdomen is required, however, CT should be the initial examination. In this case an IVU is seldom needed. Further investigation with angiography may be indicated, either because of CT results or clinical assessment of the patient. ◀

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DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Ian C. MacLean, M.D., Chicago, was elected member-at-large of the Board of Governors of the American Academy of Physician Medicine and Rehabilitation at its 48th Annual Assembly in October. This post leads to the presidency of the organization after a five-year service period. Dr. MacLean is an associate professor in the department of rehabilitation medicine at Northwestern University Medical School. . . .**John A. McMahon, M.D.,** Mt. Prospect, has been chosen as the first recipient of the "Mother Frances Award" of Holy Family Hospital, Des Plaines. . . . **Richard A. Perritt, M.D.,** Chicago, has been named president-elect of the International College of Surgeons, United States Section. Dr. Perritt, a pioneer in ophthalmic microsurgery, maintains a private practice in Chicago.

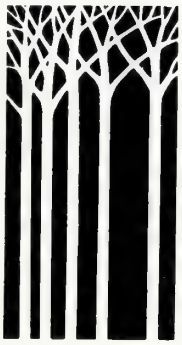
Ramesh C. Tripathi, M.D., Ph.D., Chicago, a professor of ophthalmology at the University of Chicago, is a recent recipient of the National Federation of Asian Indian Organizations in America's honor award. . . .**L. Chatman, M.D.,** Chicago, has been elected vice president of The American Association of Gynecologic Laparoscopists. Dr. Chatman, vice chairman of the department of obstetrics and gynecology at Michael Reese Hospital and Medical Center, Chicago, is an associate clinical professor in the department of obstetrics and gynecology at the University of Chicago. . . .Two members of the department of obstetrics and gynecology at Loyola University Medical Center were honored recently by the medical students for their teaching abilities. Named "Best Attending Teacher of the Year" was **John G. Gianopoulos, M.D.,** River Forest, an assistant professor of obstetrics and gynecology. Chosen "Best Teaching Resident of the Year" was senior resident, **Robert T. Kus, M.D.,** Chicago. . . **Milton Weinberg, Jr., M.D.,** Evanston, has been appointed chief of cardiac surgery at Lutheran General Hospital, Park Ridge. Dr. Weinberg, former medical staff president at Rush-Presbyterian-St. Luke's Medical Center, is also president-elect of the Illinois Surgical Society.

PROJECT USA SEEKS PHYSICIANS

Physicians are asked to support Project USA, an AMA program which recruits fully licensed physicians for short-term, general medicine assignments at Indian Health Service (IHS) and National Service Corps (NHSC) hospitals and clinics.

Payment and living accommodations are provided. Participants receive $750 per week at IHS facilities and $500 per week at NHSC clinics. Assignments are for two or four week periods, and round-trip travel expenses are reimbursed. Information may be obtained by contacting John Naughton, Project Director, AMA, 535 N. Dearborn, Chicago, Illinois 60610; (312) 645-4702. ◀

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February

Pathology

Overview of Chicago Blood Banking; Controversies in Blood Banking: Direct Donation
For: Pathologists. Lecture, February 9, 7:00 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Surgery

Review Course in Neurological Surgery
For: Neurosurgeons, neurologists. Lecture, February 6-15, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $880. **Reg. Limit:** None. **Credit:** Category 1: 104 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Specialty Review in General Surgery, Part II
For: General and specializing surgeons. Lecture, February 16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $880. **Reg. Limit:** None. **Credit:** Category 1: 103 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Neurology

The Biologic Basis of Neurology and Psychiatry
For: Neurologists and psychiatrists. Lecture, February 23-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $670. **Reg. Limit:** None. **Credit:** Category 1: 42 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

MARCH

Clinical

43rd Annual Midwest Clinical Conference
For: Physicians of all specialties, March 6-8, Chicago. **Sponsors:** Chicago Medical Society, 515 N. Dearborn, Chicago, IL 60610, and 40 contributing specialty societies. **Fee:** Pending. **Reg. Limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Christine Ricker. **Phone:** (312) 670-2550, Ext. 254.

Sports Medicine

Third Annual Sports Medicine Conference
For: Physicians. Symposium, March 14, Rockford. **Sponsors:** University of Illinois College of Medicine at Rockford, Department of Community Medicine, Rock River Chapter of the American Red Cross, Rockford Memorial Hospital, St. Anthony Medical Center, Swedish-American Hospital, and the University of Illinois Medical Alumni Association. **Fee:** $20. **Reg. Limit:** None. **Credit:** Category 1: 8 hours. **Contact:** Office of Continuing Education, University of Illinois, College of Medicine, 1601 Parkview Avenue, Rockford, IL 61107. **Phone:** (815) 987-7140.

Pathology

General Concepts of Graft vs. Host Reaction
Pathology of the Liver Related to Transplantation
Pathology of Heart Transplantation
For: Pathologists. Lecture, March 16, Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

APRIL

Pathology

T-Cell Lymphomas
For: Pathologists. Lecture, April 13, Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Orthopedic Surgery

Surgery of the Spine: State of the Art
For: Orthopedic and neurological surgeons. Symposium, April 29-May 2, St. Louis, MO. **Sponsors:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104 and Cardinal Glennon Childrens Hospital. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 24 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

May

Neuroradiology

1987 Neuroradiology Review Course
For: General radiologists, neuroradiologists, neurosurgeons, neurologists, and residents. Course, May 2-3, Oakbrook Marriott Hotel, Oak Brook, IL. **Sponsor:** Loyola University Medical Center, 2160 South First Avenue, Maywood, IL 60153. **Fee:** $170 for physicians and $100 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3237.

Pathology

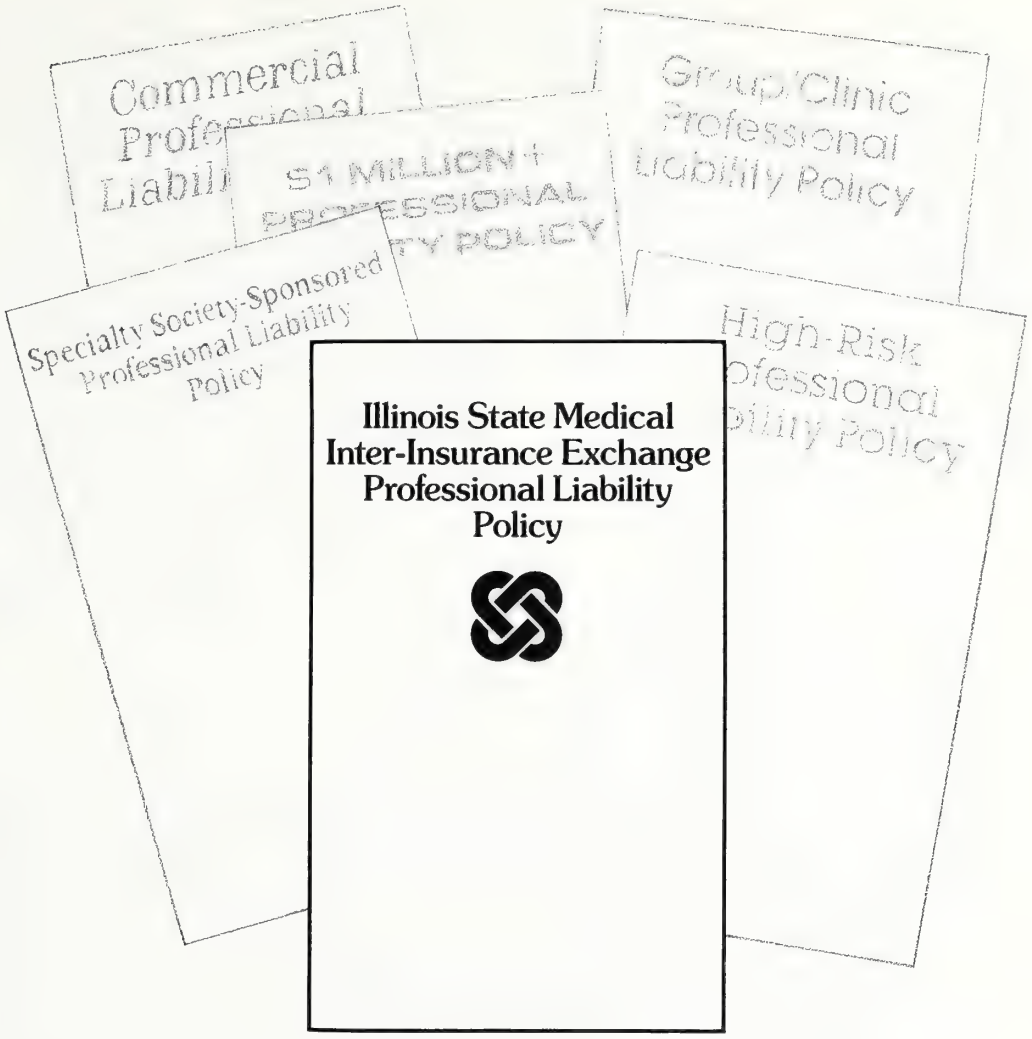
Current Problems in Cervical Neoplasia
For: Pathologists. Lecture, May 11, Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

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EKG

(Continued from page 14)

Answers: 1. C, D 2. A, B, C, D, E

The ECG shows a normal sinus rhythm at a rate of 90 beats per minute. The PR interval is normal at 0.16 seconds and the QRS duration is 0.10 seconds. The large Q waves in leads I and AVL suggest an anterolateral myocardial infarction with associated ST segment elevation. This ST segment elevation is compatible with a current of injury or a left ventricular aneurysm. The clinical presentation as well as review of old ECG tracings help differentiate these two conditions. Serial cardiac enzymes and comparison of this ECG with older ECGs ruled out a new myocardial infarction. The persistence of ST segment elevation associated with infarction Q waves is compatible with a left ventricular aneurysm. This would be in agreement with the cardiomegaly on the chest X-ray. A two dimensional echocardiogram or radionucleotide angiogram would further confirm the presence of the ventricular aneurysm.

This patient presents with congestive heart failure, and would benefit from more medical management. Unfortunately, although this may eliminate congestive symptoms by increased diuresis and weight loss, it may not make the patient feel better. Symptoms of dyspnea and orthopnea can be eliminated, but often the result is a worsened fatigue because results include a low cardiac output state. Decreases in ventricular volume and end diastolic pressure with diuresis may not increase the cardiac output. The full assessment of the heart requires cardiac catheterization as well as coronary and left ventricular angiography.

Since our efforts to manage medically had limited success, the patient agreed to the cardiac catheterization. This showed a large well-demarcated anterolateral and apical left ventricular aneurysm with significant triple vessel coronary artery disease.

Although the patient is technically a surgical candidate, left ventricular aneurysmectomy does not always result in improvement, especially in the absence of angina. The reasons for this are thought to be an insufficient aneurysmectomy, or an aneurysm that is not well-demarcated and cannot be resected at all.[1]

Although many patients improve after surgery, this may be due to the usual addition of coronary bypass grafting to the aneurysmectomy, and not direct improvement in ventricular function.[1] Our patient agreed to the surgery and was improved postoperatively. Eventually newer inotropic agents may provide the needed improvement in ventricular function.[2] ◀

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Sunset Review: The Time Is Now



All of the ISMS membership is now aware of and, hopefully, actively working toward our legislative initiative: a $250,000 cap for noneconomic damages and a reasonable statute of limitations for minors injured because of medical negligence. Unfortunately, a great number of physicians are not aware of another very important task that faces us in the General Assembly this year. What I refer to is "sunset" review of the Medical Practice Act. The legislature must review that Act (and other statutes regulating allied health care professionals) in full this year, before the law's scheduled termination or "sunset" date of year-end 1987.

Most of us have not had the occasion to think much about the Act under which we are licensed. But we certainly better begin paying attention to it now!

If we ignore the importance of the Medical Practice Act, we could find ourselves licensed alongside groups with which we have little or nothing in common. Indeed, several groups not currently licensed under the Medical Practice Act may seek licensure. Others who are already licensed will seek to broaden their activities. The results of this could be catastrophic—particularly to patient care. We have an obligation to help safeguard the health and welfare of our patients. And one way we can do so is by opposing licensure or the broadening of licensure authority by those not trained to have independent practice authority.

We have heard about so-called consumer groups, as well as legislators, who wish to attach some very objectionable items to physician licensure. Some examples are:

- making mandatory Medicare assignment a requirement for state licensure; or
- increasing medical licensure fee to $500 per year (currently $35 per year).

These are just two of the many, potentially onerous provisions we could face in the General Assembly this spring.

ISMS Chairman of the Board, Alfred J. Kiessel, M.D., has formed an Ad Hoc Committee to work on the Medical Practice Act rewrite. This committee will meet with those individuals who have impact on licensure. It will vigilantly guard against changes adversely affecting ISMS members and our patients.

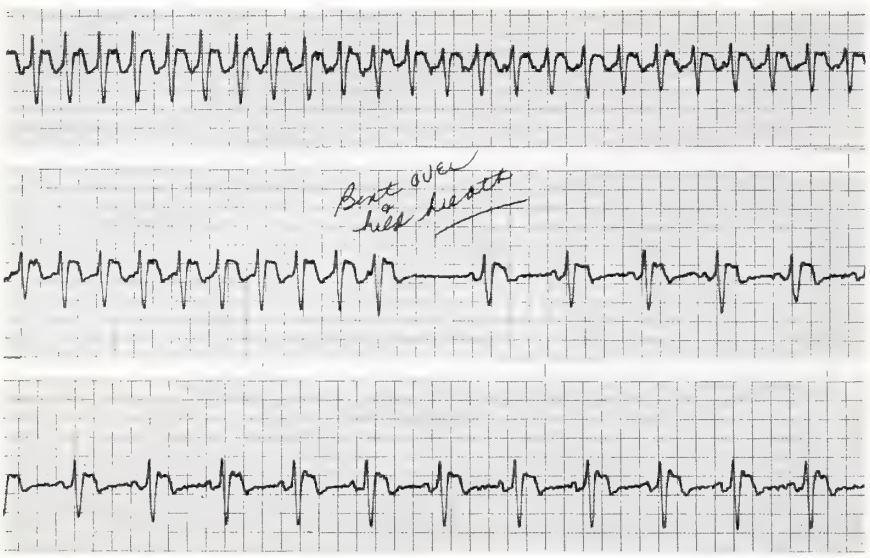
It would certainly be easier not to face two such important issues in the same year. But we do not have that luxury. We cannot afford to choose either tort reform or the Medical Practice Act's review as "more important," thus neglecting the other.

If we are to achieve our goals of safeguarding quality care for patients and maintaining a sound environment to practice our profession, our state medical society must speak as a strong unified voice. It is my sincere plea that all members get behind our efforts in a unified way. The presence of self-interest factions will have nothing but a negative effect on a successful outcome. If anyone would like to provide input, let us hear from you. ◀

Jere E. Freidheim, M.D.
President

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was a fifty-seven-year-old man with a history of palpitations dating back to childhood. These episodes were usually short-lived, and essentially never associated with symptoms other than palpitations. The patient discovered that breath holding, squatting, or Valsalva maneuvers helped eliminate the palpitations. His tachycardias continued to be stable and manageable. In the mid-1960s digitalis and quinidine were tried, but the patient discontinued them when he developed diarrhea. In the late 1970s disopyramide was tried, but failed to prevent the palpitations. In 1980 he had a severe and particularly prolonged episode accompanied by a severe, sharp, interscapular back pain. An acute myocardial infarction was diagnosed and the patient was hospitalized for two weeks. Two weeks after hospital discharge, the palpitations recurred. Digoxin was given and later procainamide was added, but these drugs did not control the palpitations.

The patient had a history of hypertension, a fifteen year, one pack per day history of cigarette smoking stopped at the time of the infarction, hyperlipidemia and positive family history for coronary artery disease.

In the office, his blood pressure was 112/90mmHg and his pulse was 64 beats per minute. Examination was normal except for cardiac exam, where an atrial gallop (S4) could be palpated and auscultated. Chest x-ray showed a normal heart size. A twelve lead ECG showed an old anteroseptal myocardial infarction, complete right bundle branch block, left axis deviation and sinus rhythm with a normal PR interval. Since the episodes of palpitations were irregular, an arrhythmia monitor was ordered for the patient, enabling him to transmit his ECG over the telephone during an episode. Two days later, he sent this ECG rhythm strip. (Figure reads: Bent over and held breath.)

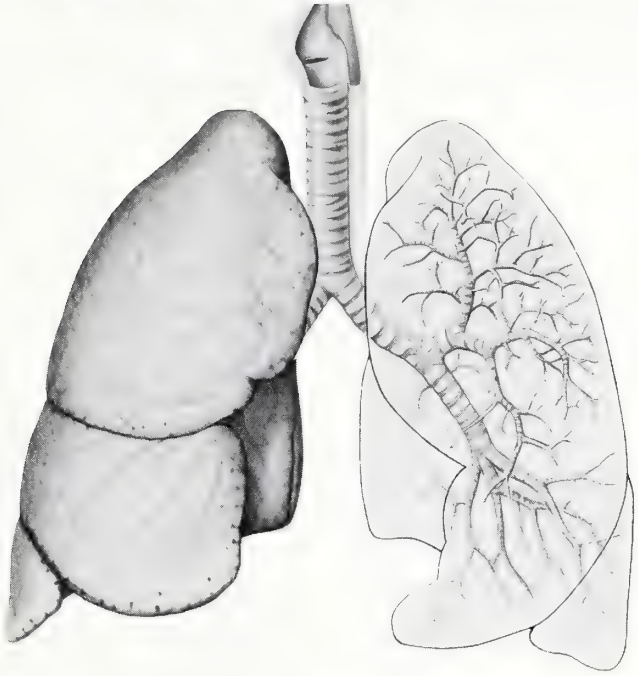
Questions:

1. **The telephone transmitted ECG rhythm strip shows:**
   - A. Paroxysmal ventricular tachycardia.
   - B. Paroxysmal supraventricular tachycardia.
   - C. Paroxysmal atrial flutter with 2:1 atrioventricular (AV) block.
   - D. Paroxysmal atrial fibrillation.

2. **A treatment plan for this patient could include which of the following:**
   - A. Multiple gated acquisition radionuclide ventriculogram to evaluate the left ventricular ejection fraction.
   - B. A thallium exercise electrocardiogram.
   - C. An electrophysiology study.
   - D. A coronary angiogram.
   - E. Serial drug testing.

(Continued on page 109)

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Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
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- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
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600332

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Pelvic inflammatory disease is the most common serious infection among women of childbearing age; more than 250,000 require hospitalization annually. Most patients received a single antibiotic, with a shift in treatment from natural penicillin in prior years to aminopenicillin, tetracyclines and cephalosporins. Since no single type of organism appears to be the culprit, the Centers for Disease Control have recommended a two-drug regimen of broad spectrum antibiotics. The drugs most often used are the cephalosporins and tetracyclines. (Grimes, D., *et al.: JAMA* 256:23,3223-6, 1986)

A double-blind clinical trial was used to evaluate the efficacy of intravenous heparin in 225 patients with progressing or evolved strokes on basis of thrombosis. Heparin or a placebo was administered for seven days. Patients were evaluated neurologically and functionally at the end of the seventh day, the third month and the first year of treatment. No statistically significant difference was observed in the two groups, and the use of intravenous heparin in patients with strokes is not recommended. (Duke, R., *et al.: Ann Intern Med* 105:6,825-8, 1986)

The literature was analyzed to determine the efficacy of various prophylactic methods employed to prevent post-operative deep vein thrombosis. It was the authors' impression that only 25% of American surgeons used any prophylactic measures, compared to 50% of European surgeons. General procedures used were intermittent pneumatic compression, gradient compression stockings, heparin and dihydroergotamine, or a combination of these. The best results were achieved using intermittent pneumatic compression with gradient compression stockings; least effective was the use of heparin. The authors further suggest greater use of prophylactic measures in the prevention of deep vein thrombosis and embolization. (Colditz, G., *et al.: The Lancet* 8499:143-6, 1986)

The addition of amino acids is insufficient in the treatment of patients with loss of proteins due to injury, sepsis, or chronic disease. Glutamine may be a significant factor in the synthesis of muscle proteins. It plays an important role at the muscle membrane as a transporter. Injury, sepsis and chronic diseases result in an intramuscular rise in Na and Ca ions, a depression in K ions, and can cause a large, rapid loss of muscle glutamine, up to 60% of the body's free pool of nitrogen. It is the most rapidly transported amino acid. (Rennie, M., *et al.: The Lancet* 8514: 1008-12, 1986)

Profuse sweating, particularly of hands, soles of feet and in the axilla, can be very disconcerting and emotionally distressing to patients. Excessive perspiration can be accentuated by mental and physical stimuli, and may require medical management. Treatments range from the application of topical agents such as aluminum chloride on dry areas for 6-8 hours before removal; tanning agents as glutaraldehyde and iontophoresis and the removal of some of the stratum corneum by applying repeated strips of tape to the skin. Also used are systemic anticholinergics, biofeedback and surgery. It is suggested that topical medication, the anticholinergic agents and surgical procedures be utilized in that order. (White, J.: *Mayo Clin Proc* 61:12;951-56, 1986)

Bed rest is the most common therapeutic modality in patients with complaints of mechanical low back pain without neurologic complications. The duration of this bed rest has varied among clinicians. A follow-up evaluation was performed at three weeks and three months on 203 walk-in patients with low back pain syndromes. One group had two days of bed rest, the other had seven. Data showed that individuals on two days' bed rest missed 45 fewer days of work, but otherwise, no functional, physiological or perceived difference in outcomes was found. (Deyo, R., *et al.: N Engl J Med* 315:17,1064-70, 1986)

Heavy alcohol consumption in men is an important and under-recognized independent risk factor for stroke. Weekly alcohol consumption of 10-90g reduced the risk of stroke compared to nondrinkers, but men consuming 300g per week showed a four-fold increase in risk. Excess alcohol consumption was confirmed by the elevated biochemical markers of aspartate aminotransferase, uric acid, and gamma-glutamyl transferase. The population group studied was aged 20-70, matched for age, sex and race. No significant data were obtained on women drinkers, since their alcohol consumption was minimal. (Gill, J., *et al.: N Engl J Med* 315:17,1041-6, 1986)

The prevalence of functional disabilities secondary to major neurologic disorders was studied. Evaluated were 23,842 residents of one county. Of these, 246 showed severe functional impairment because of cerebral palsy, epilepsy, stroke, Parkinson's disease or severe dementia. Constant supervision was required by 59 patients because of cognitive difficulties, 108 were not ambulatory and 54 had at least one afebrile seizure monthly. The incidence of these disabilities increased with the age of the patients. (Haerer, A., *et al.: Arch Neurol* 43:10,1000-3, 1986) ◀

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A GREAT WAY TO SERVE

Losing the Battle But Winning the War

In July, 1983, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwin began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

Universally, change is met with resistance. But nowhere is that resistance as great as in Mt. Hawley. Several years ago the coalition of purveyors of brown bags, thermos bottles, and lunch buckets ran a candidate for the School Board to support their position against the hot lunch program. Clearly in their minds and in the minds of their supporters, the hot lunch program was an insult to mothers who had always prepared peanut butter and jelly, meatloaf and roast beef sandwiches for their school-going offspring. The whole concept was downright un-American.

Knowing that mind set, the groundswell of hostility and outrage that recently occurred was not surprising. Milt Schroeder's Ford Agency made a drastic turn, and, as hard as it is to believe, became Schroeder's Ford-Nissan Agency. Not too hard to understand the outrage and the rhetoric that developed at the Apollo Cafe the day after that big sign was erected. Old Asa, sitting with his chair propped back against the wall, baseball cap with the "Seed Feed" logo tipped over his eyes and resting on his nose, had apparently had about as much of the comments as he could stomach. He straightened up his chair, tilted his baseball cap back, cleared his throat; just as E. F. Hutton gets listeners, so did Asa. "We really ought to learn from the Japanese instead of being mad at 'em. What the Japanese learned was that the time to fight a war is while the war is going on. But once the war is over, that's the time to capture the enemy in a non-military way."

There was a numbed silence after that declaration. And then people began to mutter about all of the Japanese imports and other technical material that they were seeing—even posters and that new microwave cooker—turning up with Japanese names. It seemed to me that a sense of resignation spread over the Cafe, even with the muttering, "buy American," "gotta support our workers," and other like comments.

As I read in the *IMJ* and other journals, it seems to me that you doctors could learn a little from the Japanese, and from old Asa as well. It may be that with medical affairs, as well as with military affairs, the time to fight the battle is before it's won or lost. When the battle is lost on Medicare or PROs or DRGs or any of the other alphabets, it is over. Talk of repealing a law or reversing a battle just don't make sense. How many laws can I remember that have been repealed? I checked it out with old Asa, and he couldn't remember any either.

So once the battle is done, it may be that the thing to do is to borrow a page from the Japanese, and attempt to capture the system in another way. The Japanese did it by trading us out of our businesses; beating us at what we thought we did best. It may be wise for physicians to realize that all of those alphabets are here to stay, and start to figure out how they can capture that for their own use. Making physician organizations from the PROs and HMOs and IPAs and so on is more do-able than trying to eliminate them and fighting a battle that has already been lost. Again, it seems to me that old Asa has boiled down the issue to a level that even I can understand. Perhaps your docs can as well. ◀



Yours,
E. Goodwin

THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Preparing for 1987

Contract Vigilance

Between 1983 and 1986 the number of HMOs operating in Illinois has more than tripled. Although the final figures are not yet available, it is estimated that the report will reflect an enrollment of at least one and a half million Illinois consumers in HMOs. The rate of increase in the number of PPOs operating in the state between 1983 and 1986 is even greater. As the pace of physician contracting for the delivery of health care accelerates, The Informed Physician prepares to meet the challenge with the aid of the Office of Contractual Services, a knowledgeable attorney and a knowledgeable financial advisor.

The Informed Physician combines the prudent mind of a business person with the caring attitude and sharp intellect of a physician. This dual role requires that certain resolutions are in order for 1987.

Suppose the ABC PPO invites the physicians with staff privileges at XYZ Hospital to attend a meeting where the HMO sales representative explains the advantages of its Physician Provider Agreement. The sales representative extols the benefits that flow to those physicians who sign the contract, such as an increase in patient volume which will absorb the discount in the physician's fees, thereby making the contract economically viable. The sales representative does not disclose that there are no guarantees that the physician's number of patients will increase. The sales representative may also state that the PPO will in no way interfere with the physician/patient relationship. However, the sales representative may not explain that the utilization restrictions and prior approval requirements may result in the denial of payment for care rendered, which would result in an economic loss to either the physician, the patient, or both. Some physicians at the meeting queue up and sign the contract before reading and studying it.

The Informed Physician Resolves: *Not to sign a contract without carefully reading and fully understanding all its provisions, in addition to consulting a knowledgeable attorney.*

Suppose the HMO contract you are considering contains an indemnification and hold harmless clause. (See December *IMJ*, 170:6,364, 1986 for a detailed examination of such clauses.) Most professional liability insurance policies, including the Illinois State Medical Inter-Insurance Exchange policy, specifically exclude from coverage those liabilities which the physician assumes because of a contract. And that's exactly what an indemnification and hold harmless clause is: a contractual agreement to assume someone else's liability.

The Informed Physician Resolves: *To consult a knowledgeable attorney, your professional liability insurance company and your comprehensive general liability insurance company about the specific indemnification clause in the contract you are considering.*

Suppose the contract you are considering contains the following statement. "Physician agrees to abide by the ABC PPO utilization review policies, procedures, rules and regulations as they now exist and as they may be changed by ABC PPO from time to time." The contract does not contain in its exhibits or attachments what the current utilization review policies, procedures, rules and regulations are, so it is impossible to evaluate whether such review mechanisms adequately address quality of care. The contract does not state if the physician providers have any input in the development or adoption of such

review mechanisms, or whether a fair appeals process is available. The contract does not state whether notice to and the consent of the physician is required before changes are effective, or whether the physician has the option to terminate the contract if the changes are unacceptable.

The Informed Physician Resolves: *Before signing a contract which makes vague references to the unknown utilization review policies, to obtain, carefully examine and fully understand the policies, procedures, rules and regulations. The Informed Physician realizes that the utilization review standards determine whether you are able to render quality health care under the contract. Consult with a knowledgeable attorney to clarify contractual ambiguities. (Look for upcoming columns on the effect of physician contracting and your professional liability.)*

Suppose you are the president of an IPA (Individual Practice Association) and are considering a contract with ABC HMO. The HMO will pay your IPA a fixed amount per month, per person enrolled in the HMO/IPA. Your IPA must pay for all the covered health care services used by HMO contract patients, and pay the IPA physicians for their services from monies received from the HMO. Contingent liability insurance and stop loss insurance are other IPA expenses.

The Informed Physician Resolves: *Not to enter into a contract between an HMO and an IPA without first consulting your financial advisor and a knowledgeable attorney. (Look for upcoming columns on IPAs.)*

Suppose the HMO contract you are considering contains an automatic renewal clause, which means that unless you give written notice to the HMO within a certain number of days (it could be up to 120 days) before the anniversary date of the contract, the contract automatically renews for another year. If your decision to terminate the contract occurs after the required notice period, you could be locked into a contractual arrangement unsuitable to you for well over a year. Additionally, contracts which provide for automatic renewal may foreclose renegotiation of fees and other contractual terms. Contract termination does not automatically terminate the physician/patient relationship. A malpractice claim may arise if an injury results from the physician's refusal to continue treatment through a period of later complications. The refusal to provide further care without giving the patient reasonable time to find substitute care constitutes patient abandonment. (See January *IMJ*, 171:1,16, 1987 for a detailed examination of such clauses.)

The Informed Physician Resolves: *To examine carefully and understand fully the contract termination clause, and to consult a knowledgeable attorney.*

Because you're an informed physician who recognizes the complexity of these contracts, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you objective comments on any HMO, PPO or IPA contract at no cost. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The Informed Physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO, or IPA, you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

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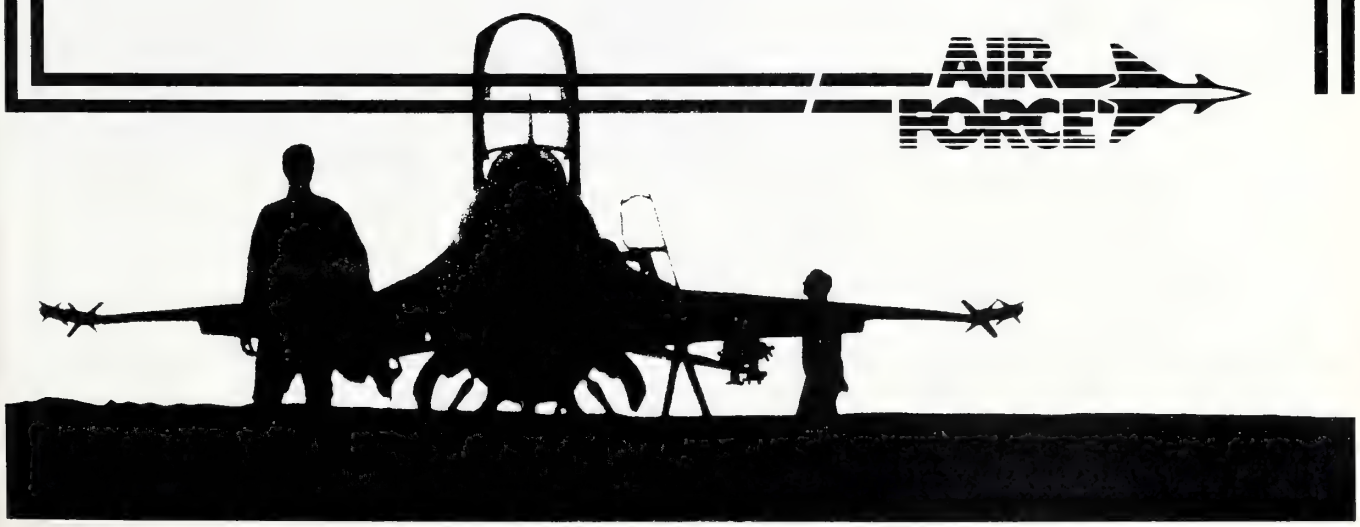
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AIR FORCE



Action Team Update

Physician "action teams" organized by hospital medical staffs and county medical societies are beginning in earnest their 1987 efforts to enlist legislative and media support for additional malpractice reforms.

To date, scores of action teams have been organized by physicians across the state. Similar teams were the backbone of the medical profession's successful drive for broad malpractice reform legislation in 1985.

The Illinois State Medical Society (ISMS) has called upon its member physicians to organize in similar fashion for 1987. The Society intends to propose legislation calling for a cap on awards for noneconomic damages such as "pain and suffering" and a revised statute of limitations for suits involving the treatment of minors. The legislation will be offered during the spring session of the Illinois General Assembly.

Many action teams already have had initial meetings to plan their efforts, and some already have met with their state representatives and senators to press their arguments for additional reforms.

One such meeting took place January 7 at the **Medical Center of Lake County** in Libertyville. The Medical Center's action team, which includes representatives from the medical staff, governing board and administration, is headed by **Dr. Francis Jeffords.** Other physician members of the team include **Ed May, M.D., Ed Hobart, M.D., James Creath, M.D.** and **John Ring, M.D.**

The Medical Center's action team met with State Senator **David Barkhausen** (R-Lake Forest), and State Representatives **Virginia Frederick** (R-Lake Forest) and **Robert Churchill** (R-Antioch). All three legislators expressed general support for further tort reform, although they predicted that placing a cap on noneconomic damages would be a difficult task.

Another physician-legislator meeting took place December 16 between State Senator **Jerome Joyce** (D-Bradley) and physicians of the Iroquois County Medical Society. Senator Joyce was invited to the Society's annual dinner, where a lively exchange took place between the senator and the physicians of Iroquois County and their spouses.

The event was organized by **Dr. Kent Swedlund,** action team leader of **Iroquois Memorial Hospital** in Watseka. Other physicians involved in the Iroquois County efforts are **Dr. Mohammed Razvi,** the county society's president; **Dr. Norman Hungness,** the county society's secretary; and **Dr. Delos Cozad,** action team leader at **Central Community Hospital** in Clifton.



Attending the action team meeting at St. Therese Medical Center were (seated left to right): State Senator Adeline Geo-karis (R-Zion) and Debra Halas, legislative aide to State Representative John Matijevich (D-Waukegan). Also present at the meeting were action team members (left to right): Thomas Onan, Governing Board member; Manoochehr Sharifi, M.D., medical staff president; John Curns, M.D., immediate past president of medical staff; Gerald Frank, M.D., action team leader; and Marguerite G. Turpel, vice-president of professional services. Action team members not pictured: Leo F. Garrison, vice-president of operations; Alfred W. Mansfield, vice-president of corporate finance and Kenneth Rickman, Governing Board.

Physician Action Teams

The Key to Further Malpractice Reform

Given the intense opposition by plaintiff attorneys to further revisions in the laws pertaining to medical malpractice, physicians will need a widescale effort in 1987 to achieve passage of additional legislation. As in 1985, the Illinois State Medical Society is urging hospital medical staffs and county medical societies to organize action teams to focus physician efforts in gaining support among legislators, the news media, and their local communities.

ISMS recommends that each action team consist of a team leader and at least three other physicians to coordinate efforts in each of the key areas.

Physicians already involved in organized medicine (*i.e.,* county medical society officers, ISMS and AMA delegates, ISMS and AMA Hospital Medical Staff Section representatives, and Illinois State Medical Inter-Insurance Exchange Network representatives) are prime candidates for action team membership.

Other concerned individuals also should be considered for action team membership, according to ISMS. These would include:

- *Hospital administrators.* Hospital officials can provide important information on how a hospital is being affected by the liability crisis (*e.g.,* emergency room costs, percentage of daily room charges, etc.).
- *Hospital governing board members.* Board members usually are prominent people in the community who can provide a credible perspective on the problem.
- *Hospital attorneys.* A hospital's legal counsel can provide information on legal issues and can help dispel the misconception that the entire legal community opposes tort reform.
- *Medical staff coordinators.* The coordinator can provide valuable assistance in disseminating information to the medical staff and following up on various activities of the action team.
- *Hospital public relations personnel.* Hospital PR people can help arrange media contacts and facilitate public communications.
- *Other interested parties.* Auxilians, nurses, dentists, podiatrists, and allied health personnel also can provide special expertise.

ISMS also has outlined a series of key activities for action teams to undertake to help bring about success in Springfield in 1987, including:

- Personal meetings with legislators.
- Presentations before local community organizations such as Rotary, Kiwanis, Jaycees, Lions, and Chambers of Commerce.
- Interviews with local newspaper, radio, and television reporters.
- Letters to the editors of local newspapers and meetings with the papers' editorial boards to generate editorials expressing support for physician efforts.
- A display of information within the hospital on how physicians and others can contact local legislators.
- A "telephone tree" to speed communication with medical staff and hospital personnel as events unfold within the General Assembly.

ISMS is urging all physician action teams to work diligently in the weeks ahead. In the Society's view, the key to success in 1985 was the huge amount of momentum that was generated by beginning work early. And the Society maintains that an even greater effort will be needed for success in 1987. ◂

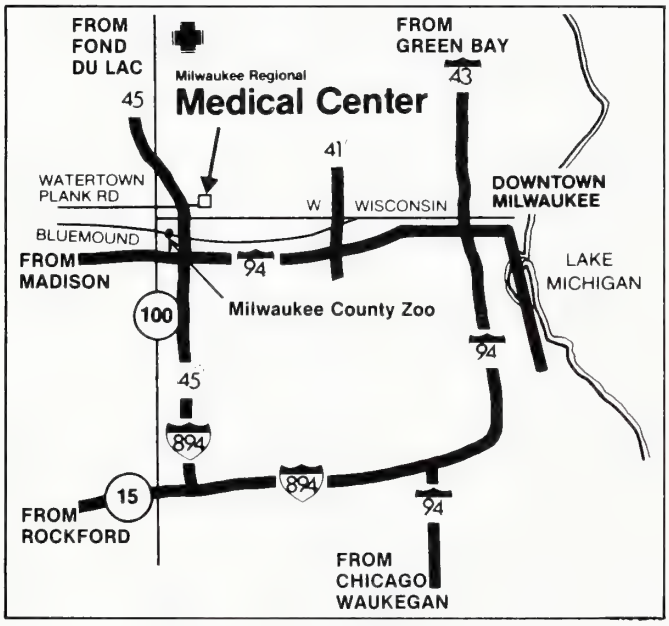
Key physicians from neighboring Kankakee County also attended the meeting with Sen. Joyce, including Kankakee County Medical Society President **Dr. Nicholas Slimack; Dr. Donald Parkhurst,** action team leader at **Riverside Medical Center;** and **Dr. Charles Lind,** secretary of the Kankakee society and action team leader at **St. Mary's Hospital.** State Representative **Charles Pangle** (D-Kankakee), a longtime supporter of malpractice reform, had been invited to the meeting, but was unable to attend.

St. Therese Hospital's action team (Waukegan) held a luncheon meeting with State Senator **Adeline Geo-karis** (R-Zion) on January 9. Along with representatives from the governing board and administrators, physicians present included **Gerald Frank, M.D.** (action team leader), **John Curns, M.D.** and **Manoochehr Sharifi, M.D.** Senator Geo-Karis told the group she supports a cap and a reduced statute of limitations for minors, but predicted a tough fight over these proposals. State Representative **John Matijevich** (D-Waukegan) was unable to attend the meeting but sent an aide. ◂

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Illinois State Medical Society

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From Occult Pelvic Inflammatory Disease

Peritonitis and Small Bowel Obstruction

By Dennis J. Baumgardner, M.D. and Donald E. McCanse, M.D./Rockford

Perihepatitis, a recognized sequela of chlamydial and gonococcal pelvic infection, involves localized peritonitis and subsequent inflammatory adhesions. The preceding pelvic infection or colonization may produce few symptoms, if any, and offending organisms may be disseminated in the abdomen during acute infection, or by manipulation of a colonized genital tract. We report the case of a young woman with small bowel obstruction due to spontaneous inflammatory adhesions, apparently secondary to localized peritonitis from occult Chlamydia trachomatis *genital infection. Clinical, historical, serological and reference data are given to support this hypothesis. A review of the clinical features and pathophysiology of perihepatitis is provided.*

Localized peritonitis in the form of perihepatitis has been recognized as a complication of pelvic infection (the Fitz-Hugh—Curtis syndrome) since its original description in Spanish literature[1] and later in the American literature.[2,3] Perihepatitis was thought to be solely a complication of gonococcal pelvic inflammatory disease (PID), and only sparse reports appeared in the literature after Stanley's comprehensive review in 1948.[4] Recent reviews, however, have called more attention to this expanding and underdiagnosed clinical entity.[5-11]

Since the 1978 report of Muller-Schoop, *et al.*,[12] associating *Chlamydia trachomatis* with perihepatitis, and the subsequent isolation of this organism from the liver capsule of a Fitz-Hugh—Curtis patient,[13] *C. trachomatis* has been recognized as perhaps the most common cause of this entity. At the time of diagnosis of Fitz-Hugh—Curtis syndrome, cervical cultures for *Neisseria gonorrhoeae* are usually negative. The occurrence in some series of presumed *C. trachomatis* perihepatitis is not related to the recovery of the organism from the cervix.[14] In untreated chlamydial cases, approximately half of patients have positive cervical cultures. However, over 80% have elevated *C. trachomatis* antibody titers.[6]

Careful history and physical exam will reveal current or recent genital tract infection in the majority of perihepatitis patients, although this is often very subtle and may be missed completely.[6,11] In some cases there are no signs or symptoms of recent genital tract infection.[9,11,12] In one series[12] only two of eleven patients with laparoscopically-proven perihepatitis had signs of salpingitis on pelvic exam.

Of particular interest are two patients in the study of Muller-Schoop, *et al.*,[12] with serological evidence of recent chlamydial infection who had laparoscopically proven *diffuse* peritonitis. These patients had *C. trachomatis* IgG antibody titer elevations of a magnitude usually seen in the Fitz-Hugh—Curtis syndrome,[10] but had no laparoscopic signs of salpingitis or perihepatitis. The authors suggested that evidence of genitally-transmitted infections should be sought in all young women with unexplained peritonitis.

We describe a case of spontaneous localized peritonitis and small bowel obstruction in a young woman with evidence of recent occult chlamydial genital tract infection. This report suggests that small bowel obstruction may be a late sequela

of pelvic inflammatory disease, and that unexplained localized adhesions may be a result of prior genital infection with or without perihepatitis.

Case Report

A 24-year-old lactating white female, ten weeks post-partum following a normal vaginal delivery, presented to an outpatient clinic with a three-week history of intermittent aching epigastric pain. She had not experienced nausea, vomiting, indigestion, change in stools, fever, chills, or urinary difficulties. She denied taking unusual water or food, recent travel, and tuberculosis exposure. Past medical history was unremarkable except for an innocent heart murmur and smoking. The patient took no medication other than prenatal vitamins and acetaminophen and denied alcohol use. She had no history of surgery or significant trauma. The patient repeatedly denied having had sexual intercourse since her vaginal delivery 10 weeks before. Her menses had not returned since delivery. She denied any history of pelvic pain, unusual vaginal discharge, or sexually transmitted diseases. A recent postpartum gonococcal cervical screen was negative.

Examination revealed a soft abdomen with active bowel sounds. There was diffuse moderate abdominal tenderness without guarding. The patient refused hospital admission, but did consent to an upper GI x-ray, which was normal. White blood cell count was 14,800 with 67 segmented cells and 14 band forms. Hemoglobin was 15.9. Erythrocyte sedimentation rate was 16ml/hr. Urinalysis was normal. Alkaline phosphatase was mildly elevated. Amylase, lipase, serum glutamic pyruvic transaminase and gamma glutamyl transpeptidase were all normal.

The patient was admitted to the hospital early the next morning after developing persistent vomiting without hematemesis. At this time her pain was crampy in quality and generalized, although most severe in the epigastric region. There was some radiation to the sternum and mid-back. She had a normal bowel movement shortly after admission.

Repeat examination revealed a moderately ill, thin, afebrile, nonicteric white female in obvious pain. Vital signs were normal. Pertinent physical findings were limited to the abdomen and pelvis. The abdomen was soft, slightly protuberant and tympanitic, with very active bowel sounds. Bilateral costovertebral angle tenderness was present, in addition to marked generalized abdominal tenderness. There was no localizing tenderness, rebound or guarding. Rectal exam was tender in all areas. Pelvic examination revealed normal external genitalia and vagina. The cervix was inflamed and mucopurulent discharge per os was observed. Bimanual exam revealed tenderness throughout the pelvic and lower abdominal region. Adnexa were markedly tender with no palpable masses.

White blood cell count had risen to 18,500. Urine pregnancy test was negative. Gallbladder and biliary ultrasound examination was normal. Follow-up abdominal x-rays revealed multiple dilated small bowel loops with some barium in the colon, but much residual barium remaining in the small bowel.

The patient's symptoms remained severe despite rehydration and nasogastric suction. Exploratory laparotomy that evening revealed friable fibrous and fibrinous adhesions at the root of the mesentery. This resulted in small bowel obstruction at the level of the distal ilium. The remainder of the bowel appeared normal. The liver appeared normal and free of adhesions. Ovaries and fallopian tubes appeared normal bilaterally. The small bowel adhesions were carefully lysed and the patient had an uncomplicated postoperative course.

Acute serum *C. trachomatis* micro-IF antibody titer was 1:2560. The patient was given a postoperative course of oral tetracycline. Three days after discharge her 11-week-old male son was given a course of oral erythromycin at an outpatient clinic for a presumed chlamydial pneumonia prodrome. Symptoms at that time included a two-week history of typical dry staccato cough, mild tachypnea, nasal congestion, and minimal temperature elevation. Cultures were not obtained.

Discussion

Acute pelvic inflammatory disease (PID) is the most common serious infection in young women in the United States, occurring in about 15% by age 30.[15] Most are bacterial infections, with isolates including *N. gonorrhoeae, C. trachomatis* and a variety of aerobic and anaerobic organisms. Most appear to result from a prior gonococcal or chlamydial cervicitis. An endotrometritis stage probably occurs between the cervicitis and tubal infection. Some feel that *N. gonorrhoeae* and *C. trachomatis* initiate salpingitis, and then normal aerobic and anaerobic flora may invade secondarily. About 15% of women with salpingitis have had a prior genital tract procedure performed, such as insertion of an intrauterine device (IUD), hysterosalpingogram or dilatation and curettage. Presumably, these manipulations introduce *N. gonorrhoeae,* Chlamydia and normal flora organisms from a colonized or infected lower genital tract.[15]

Up to two-thirds of Scandinavian cases and at least 20% of American cases of PID are associated with Chlamydia.[7,14,15] While no unique pathological or laparoscopic features have been described for chlamydial PID, a longer, milder clinical course is often seen with *C. trachomatis*-associated PID than with non-chlamydial forms.[14,15] In all PID cases, sterile, chronic inflammatory adhesions may result.[15] Chlamydia may remain intracellularly in the host for up to 10 years and cause latent infections.[16]

Perihepatitis, inflammation of the liver capsule and adjacent peritoneum associated with genital infection (the Fitz-Hugh—Curtis syndrome), occurs in 5%-27% of women with acute salpingitis.[8] The early descriptions of the clinical manifestations of this entity, reviewed by Stanley,[4] have remained remarkably accurate. Onset is usually sudden, involving sharp right upper quadrant abdominal pain, sometimes referred to the right shoulder. Intensity is variable, but often severe. The pain is classically aggravated by body movements, deep inspiration, coughing or laughing. When associated with pelvic pain, the peritoneal symptoms may start concomitant with or pre-

cede the pelvic symptoms. Nausea and anorexia are common; vomiting may occur. Chills, diaphoresis and headache may be present. Right upper quadrant tenderness is uniformly present, with approximately half of patients having guarding, and one-fifth a positive Murphy's sign, but clinical jaundice is absent.[6] Approximately half have low grade fever. A revealing sign is the soft hepatic friction rub, like "crunching of new snow," but this is only occasionally present. Careful history and physical examination usually reveal evidence of prior or active pelvic infection, but as discussed, these may be absent.[9,11,12]

Table 1
Clinical Entities Mimicked by Perihepatitis[4-6,8]

Cholecystitis
Biliary colic
Subphrenic abscess
Pyelonephritis
Nephrolithiasis
Perinephric abscess
Pancreatitis
Hepatitis
Perforated abdominal viscus
Peptic ulcer
Appendicitis
Abdominal trauma
Ectopic pregnancy
Pneumonia
Pleurisy
Pulmonary embolism
Herpes zoster

Typical Laboratory Findings

The erythrocyte sedimentation rate is usually elevated, and leukocytosis is common. Liver function tests, and occasionally serum amylase, may show mild abnormalities. Chest x-ray may reveal an elevated right hemidiaphragm or a small pleural effusion. Ultrasonic and radiographic gallbladder examinations are usually normal, although cholecystogram may be transiently nonopacifying due to surrounding peritonitis.[6,8] Cervical cultures may not be helpful to diagnosis,[14] but in cases of chlamydial perihepatitis, most patients have elevated IgG antibody titers.[6] If the syndrome occurs soon after initial *C. trachomatis* infection, IgM antibody may be present.[5]

Perihepatitis is most commonly confused with acute cholecystitis because it usually presents as right upper quadrant abdominal pain. In addition, this entity may present as pleuritic or sharp chest pain, right flank pain, epigastric or left upper quadrant abdominal pain. A number of clinical entities may be mimicked. (Table 1)

Surgery

At laparoscopy or laparotomy, the acute stage of perihepatitis appears as an injected liver surface and adjacent peritoneum covered with small, white spots of fibrin or fibrinous plaques.[4,8] Over a few weeks, typical "violin string" adhesions develop between the liver capsule and abdominal wall. These adhesions may persist for years and result in chronic right upper abdominal pain. Lysis of the adhesions is often curative, and division of the adhesions laparoscopically in the acute stage may prevent chronic pain.[6,8]

The pathophysiology of perihepatitis is not entirely understood. While some authors have suggested that it involves an immunological reaction to genital infections, observations and isolation of gonococcal and chlamydial organisms from the hepatic site have indicated spread of the organisms from the colonized or infected genital tract.[4,8,13,17] One hypothesis is that the organisms pass from the open ends of the fallopian tubes to the subphrenic spaces via the paracolic gutters.[8,18] The documentation of perihepatitis in a male[17] suggests other means of dissemination, such as travel through the retroperitoneal lymphatics.

The work of Holm-Nielsen[19] has shown that absorption of exudates from the human peritoneal cavity "occurs through the lymphatics of the diaphragm, mainly through the central tendon." The author suggests that spread through lymphatic channels may explain the non-random distribution of intraperitoneal adhesions in his 440 unselected post-mortem examinations. One of the sites of predilection was the terminal ileum region. However, no information was given regarding the percentage of patients with prior surgery in this area.[19] The distal ileum was the site of adhesions in our present case report.

Several reports indicate that trauma to, or manipulation, of a colonized or infected lower genital tract may result in the Fitz-Hugh—Curtis syndrome. Surgery,[4] gynecological examination, intercourse and diagnostic hydrotubation[20] have been implicated. Onsrud[18] found an increased incidence of perihepatitis in patients who developed PID within six weeks of IUD insertion, suggesting that insertion of the device facilitates spread from the infected pelvis. Pelvic signs and symptoms in IUD-using patients with perihepatitis may be subtle.[11]

Summary

We report the case of a young, postpartum female with small bowel obstruction and unexplained, localized, inflammatory adhesions. On admission the patient had clinical signs of pelvic disease (cervicitis) and a serum IgG *C. trachomatis* antibody titer of 1:2560. Wang, *et al.*,[10] demonstrated that, in patients with PID, those with perihepatitis had a mean antibody titer of 1:724 compared to 1:138 in those without abdominal dissemination. Peak IgG titers above 1:1024 have been associated with the Fitz-Hugh—Curtis syndrome.[8] Our case is reminiscent of the two cases reported by Muller-Schoop, *et al.*,[12] with spontaneous diffuse peritonitis, high IgG Chlamydia antibody titers, and no apparent salpingitis or perihepatitis. We suggest that the inflammatory adhesions in our patient resulted from localized peritonitis, secondary to abdominal dissemination of *C. trachomatis* from an infected lower genital tract. Such infection may be latent or chronic.[7,16] Classic symptoms[7] of chlamydial pneumonia prodrome in her son and denial of intercourse since delivery suggest that chlamydial organisms were present at the time of birth. Trauma of prenatal intercourse, gynecological exams, or childbirth may have aided abdominal spread of the organisms.

Localized peritonitis in the perihepatic region (the Fitz-Hugh—Curtis syndrome) is a common sequela of pelvic inflammatory disease involving *C. trachomatis* or *N. gonorrhoeae.* Perihepatitis may mimic a number of clinical entities and should be considered in the differential diagnosis of any sexually active young woman with abdominal pain. Failure to consider this syndrome may result in unnecessary diagnostic tests or surgical procedures. The preceding or concurrent pelvic infection, particularly in the case of *C. trachomatis,* may be occult or produce negligible signs and symptoms. In patients with a colonized or infected genital tract, offending organisms may be disseminated in the abdomen by surgical or diagnostic procedures, intercourse or IUD insertion. Generalized peritonitis and localized peritonitis apart from the subphrenic regions also appear to be sequelae of pelvic infections. This report suggests that such areas of localized peritonitis and subsequent adhesions may result in small bowel obstruction. Dissemination of a genital tract infection should be considered in young women with spontaneous peritonitis or small bowel obstruction. ◂

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Aortic Coarctation with Complete Occlusion

By Tien C. Cheng, M.D., and J. Maurice Pouget, M.D./Chicago

Coarctation of the aorta with complete occlusion in a 32-year-old male is described. The patient was asymptomatic excepting significant systolic hypertension noted during a premarital physical examination. Massive and severely engorged collaterals seen on angiographics were confirmed by exploratory thoracotomy.

A 32-year-old male was admitted to our institution after a premarital examination revealed hypertension in his upper extremities and no palpable pulse in his lower extremities. He was completely asymptomatic. On physical examination, blood pressure was 216/92mmHg in the right arm and 208/94mmHg in the left arm. Pulses in both arms and both carotids were equal and of good volume. The pulse rate was regular at 90 beats per minute. Slight A-V nicking was noted on funduscopic examination. No bruit was heard over either carotid. The lung fields were clear to percussion and auscultation. Cardiac examination revealed a forceful apical impulse at the fifth left intercostal space, slightly lateral to the midclavicular line. The second heart sound was accentuated and a loud fourth heart sound was present at the apex. A grade II/IV systolic murmur was heard in the upper back at the intrascapular region, where a continuous bruit could also be detected. Abdominal examination was negative. No femoral pulses were detected in either groin. Posterior tibialis and dorsalis pedal pulses also were absent. The feet were colder to the touch than the hands, but there was no evidence of trophic changes in the lower extremities. The remaining physical examination was essentially normal.

Chest x-ray revealed fullness of the right upper mediastinum, a prominent ascending aorta, and bilateral notching of posterior ribs 4-7. There was no cardiomegaly. An esophagogram showed a characteristic E sign. Electrocardiogram revealed sinus tachycardia, left anterior hemiblock, probable left ventricular hypertrophy, and prominent Q waves, possibly resulting from septal hypertrophy. M-mode echocardiogram showed no chamber enlargement and a normal aortic valve.

A cardiac catheterization was performed. Resting systolic pressures in the left ventricle and aorta were elevated (200mmHg), but there was no gradient across the aortic valve. Oxygen saturation studies revealed no evidence of intracardiac or intravascular shunt at any level. Cineangiography disclosed normal coronary arteries and a normal aortic arch. Coarctation of the aorta with complete occlusion of the lumen was noted distal to the left subclavian artery. (Figure 1) The descending thoracic aorta distal to the coarctation was filled via collaterals from the left subclavian, the left internal mammary and the left intercostal arteries. The innominate artery, the left common carotid and the left subclavian artery were all markedly dilated. The collateral vessels were tortuous, and showed aneurysmal dilatation also.

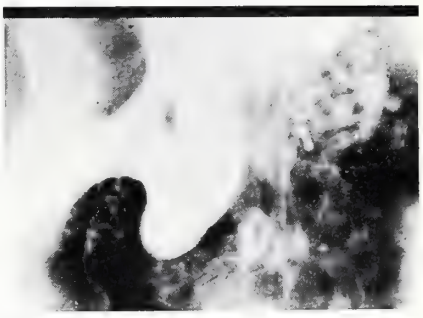


Figure 1
Aortogram shows complete interruption of the descending aorta beyond the severely engorged left subclavian artery.

Aortic root angiogram displayed a normal aortic valve without calcification or regurgitation.

A left posterolateral thoracotomy was performed several days later with removal of the fifth rib. The left subclavian artery was enlarged to the size of the aortic isthmus. The ductus arteriosus was obliterated. The coarctation was situated immediately distal to the left subclavian artery. The collaterals appeared extensive, tortuous and markedly dilated, as had been shown by the angiogram.

The coarcted segment of the aorta was removed and continuity reestablished by interposition and anastomosis of a woven dacron graft 2cms in diameter. Pathologic examination of the coarcted segment showed complete interruption of the aorta at that level and total lack of communication between the proximal and distal segments of the descending aorta. The patient's postoperative course was complicated by hypertension rising to 230/130mmHg. This was treated with an intravenous infusion of trimethaphan camsylate for 36 hours.

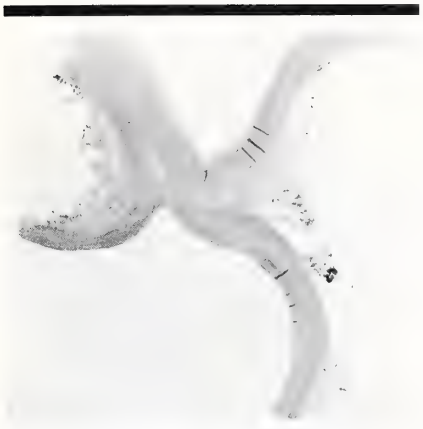


Figure 2
Pathological specimen, which cuts through the obstructed segment, showed continuous fibrous tissue between the distal and proximal segments. The intima are smooth.

Strong arterial pulses were now palpable in both femorals, as well as in the posterior tibial and dorsalis pedal vessels. After control of hypertension, the postoperative convalescence was uneventful and the patient was discharged on the ninth hospital day without antihypertensive medication.

On the day of discharge, blood pressure was 150/70mmHg in both arms. Three months later, the patient was feeling well, and had returned to work and resumed his normal activities. Blood pressure in both arms was 140/90mmHg. At last contact, ten years following this surgery, the patient was continuing to do well.

Discussion

The pathology of coarctation of the aorta is variable. It can range from a relatively minor narrowing of the aortic isthmus to complete obliteration, or total interruption, of the aortic arch, in which no connection of any kind can be found between the distal aortic arch and the descending thoracic aorta.[1] With this extreme anomaly, the descending thoracic aorta almost always communicates with the pulmonary artery via a widely patent ductus arteriosus which supplies blood to the descending aorta. Other congenital cardiac anomalies are often present, particularly ventricular septal defect and bicuspid aortic valve. Without prompt and successful surgical correction, affected infants rarely survive more than a few days or weeks. Thus, most cases have been discovered and described at autopsy, or in the neonatal period.[1-4]

A few cases of isolated atresia or interruption of the aortic arch without associated congenital anomaly have been described.[4,5] Surprisingly, and in sharp contrast, these patients appear to have a remarkedly benign course, characterized by survival to adult age, often with few symptoms or none at all.[4] Our patient clearly belongs to this group.

Of the eight such cases reviewed and reported by Dische, *et al.*,[4] six were complete interruption of the aortic arch with no connection whatsoever between proximal and distal aortic stumps. In two cases, a connection consisting of a short fibrous band still persisted. In our patient, the pathologic specimen obtained at surgery showed anatomical continuity of the proximal and distal segment, but complete obliteration or atresia of the lumen which was replaced by dense fibrous tissue.

Dische and associates postulated that the remarkedly benign course of patients with solitary interruption or atresia of the aortic arch could be explained by the absence of associated intracardiac shunts and premature closure of the ductus arteriosus in fetal life. Fetal viability would then necessitate the development *in utero* of a collateral circulation capable of providing flow to the descending aorta. Thus, at birth, a large and well-developed collateral network is already present to ensure delivery of adequate flow to the lower half of the body. This would appear to be a reasonable hypothesis, although the mechanism and reason for premature closure of the ductus arteriosus in these patients is far from clear.

Conclusions

The clinical, hemodynamic, angiographic, and pathologic findings in a 32-year-old man with coarctation of the aorta and complete obliteration of the aortic lumen are presented. The success of surgery and the postoperative reduction of blood pressure were quite dramatic, although the long term course of hypertension in these patients remains uncertain.[6,7]

This case illustrates the tremendous potential of the collateral circulation in the most severe forms of coarctation, and the gratifying results that can be obtained following appropriate diagnosis and surgical correction.

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A Complication of the Non-Fluoroscopic Technique

Pleural Placement of the Swan-Ganz Catheter

By Shahriar Dadkhah, M.D., and Mitchel P. Byrne, M.D./Evanston

Since the introduction of the Swan-Ganz catheter for the hemodynamic management of the critically-ill patient, numerous complications have been reported. We are presenting a previously non-reported complication of the non-fluoroscopic placement of the Swan-Ganz catheter, namely, extra-vascular placement of the catheter. This complication can be avoided by carefully following the steps described.

The Swan-Ganz flow-directed, balloon-tipped catheter has been used for determining pressure in the right side of the heart, pulmonary artery and pulmonary wedge in critically-ill patients since 1970. Complications such as neck hematomas, balloon ruptures, transient arrhythmias and intracardiac knotting have been reported by various institutions.[1] Infection, perforation of the pulmonary artery, vascular occlusion and infarction[2] also have been reported, as well as pulmonary arterial brachial fistula[3] and entanglement of the Swan-Ganz catheter around an intracardiac structure.[4]

We would like to call attention to a new complication which, to our knowledge, has not been reported before: the pleural placement of the Swan-Ganz catheter during percutaneous blind internal jugular placement.

Case Report

A 77-year-old white male underwent esophagectomy for carcinoma of the esophagus. At the termination of the long operation, a Swan-Ganz catheter was placed via the left internal jugular vein (by the usual non-fluoroscopic technique).[5] After obtaining blood return, the catheter was advanced. The usual wave pattern was not detected, but the catheter advanced readily and the wave form was consistent with wedged placement. Post-operative x-rays showed the Swan-Ganz catheter to be located on the left side of the mediastinum and probably below the parietal pleura. (Figure 1) The Swan-Ganz catheter was left in place for one hour for drainage, then withdrawn. Another Swan-Ganz catheter was inserted under fluoroscopic guidance via the left anticubital vein without complication.

Discussion

We would like to call attention to this unusual complication of the Swan-Ganz catheter previously unreported. Almost every possible

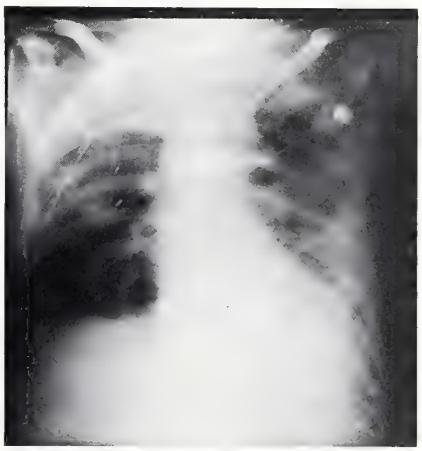


Figure 1
Swan-Ganz catheter below the parietal pleura.

complication of the Swan-Ganz placement one can imagine has occurred, and has been reported. This case report describes a complication which previously has been noted only with subclavian catheterization,[5] *i.e.,* the extravascular placement of the subclavian catheter. In our institution, there were approximately 988 Swan-Ganz catheters placed between 1979 and 1984, with a large number being placed via this technique. It appears serious complications can happen using this catheter, even in experienced hands. We report this case to point out a risk of the "blind" technique, which in theory should not occur. Despite using various precautions such as blood return, easy passage and a wave form, it is possible for extravascular placement of the catheter to occur.

It is interesting to realize that a "wave form" can be seen with a catheter in the mediastinum or in the extrapleural position as in this case. A possible explanation could be positive ventilation pressures. We suggest that if the wave obtained is not a typical atrial pressure or pulmonary wave form, one of the following procedures should be carried out: chest x-ray and/or fluoroscopy or aspiration of the catheter for blood return. If pleural placement is confirmed, immediate removal of the catheter would obviously be recommended. If, as in our case, fluids or blood had already been given, a short period of drainage via the catheter would be indicated. Fortunately, despite the frightening x-ray appearance, it seems that there may not be major sequelae to this particular Swan-Ganz misadventure. However, the goal should be avoidance of this complication by following the steps described for proper non-fluoroscopic placement. ◀

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You're on a radio or television set, awaiting that first blink of the red light to indicate the tape is rolling. What you will say and do during the next few minutes is crucial to reaching your audience, getting your message out. How will you handle tough questions? How will you explain complex medical terms? How will you come across to patients throughout Illinois?

Or perhaps you're at home reading the local edition of your daily newspaper. You wonder why the medical community's views are missing from a health care story. Or why there isn't more extensive coverage of an important issue affecting patient care in Illinois? What can you do about it?

This month the *Illinois Medical Journal* takes a look at the media that covers medical issues in Illinois and asks them what *they* think about organized medicine, emerging health care issues, the public image of physicians, and how doctors can better work with the media locally and statewide.

More than ever before, Illinois physicians are turning to the media for assistance in educating patients on key medical issues. And physicians are often critiquing media coverage of medical stories which appear in print, on radio or television. In the following article, *IMJ* probes the views of six prominent health care reporters throughout Illinois and asks their advice on how doctors can increase their media presence and effectiveness.

Those interviewed by *IMJ* are: Bruce Dan, M.D., medical editor for WLS Television in Chicago and senior editor of the *Journal of the American Medical Association;* Mary Frances Fagan, statehouse bureau chief for Springfield's WSSR Radio; Paul Gerber, senior contributing editor for *Physician's Management* magazine; Liz Isham, general assignment reporter for Rockford's WREX Television; Amy Ragsdale, health and social services reporter for the Decatur *Herald & Review;* and Howard Wolinsky, medical reporter for the Chicago *Sun Times.* More on their individual backgrounds can be found in the box on page 94.

IMJ: ***Do you find physicians generally accessible to the media and good sources for story ideas and leads?***

"I have found that a lot of doctors are doing wonderful things that people would be amazed to find out," says Amy Ragsdale of the Decatur *Herald & Review.* "But they never think to call you, probably because they're not used to dealing with reporters," she laments. Indeed, most of the six reporters interviewed agreed that physicians have great knowledge to impart to an audience that wants and needs to find out meaningful medical information. But all too often physicians miss the newsworthiness of their work for patients. Says WREX reporter Isham, "I would like doctors to feel free" to call with story ideas. "They rarely call me. I realize they're very busy people." She tracks down many physician spokespersons through the public relations office of the Winnebago County Medical Society.

Reporters such as these depend primarily on sources within the health care field to develop pertinent, interesting stories for today's health care consumers. And in turn, they offer the medical community a forum to get its message across on a frequent, regular basis. *Physician's Management* reporter Gerber notes the seeming contradiction, "I suppose from a management magazine's standpoint, one of the things we might tell doctors is 'don't waste your time with the media!' From a dollars and cents standpoint, if you're going to lock up 20 minutes of your time with a reporter, you could have seen two patients," he explains. "But we have deadlines to meet too. If you can't make time for

us, we start going other places."

WLS Television medical editor Bruce Dan, M.D., and Chicago *Sun Times* medical reporter Howard Wolinsky admit to the opposite problem: they're inundated with press releases and story ideas from physicians. But such items usually aren't suitable for objective health care reporting. "The medical community's visibility is too high," according to Dr. Dan. "I get a hundred press releases a week from people trying to market their practice. As a marketer of a consumer service, I'm opposed to that sort of concept."

He suggests instead that "doctors need to improve their visibility as caretakers of the public health." Wolinsky agrees, noting that only a "small proportion of news releases from hospitals and doctors are stories." He adds that he would like to hear more from physicians on socioeconomic issues such as Medicare and Medicaid. "In terms of doctors calling up and talking about Medicare or Medicaid, they haven't done a lot," he says.

Decatur's Ragsdale can sense when physicians are reluctant to respond to media questions. "You can tell from the moment they answer the phone there's a feeling of panic," she says. She encourages physicians to try to quell that initial reaction. Why? "Because health care is such an interesting topic for people. If they're sick, they crave information about what's wrong with them. If they're not sick, they want to know about things that can keep them well."

IMJ: ***Medical malpractice is one issue on which physicians are no longer hesitant to speak out. Have they done an effective job? How difficult will it be to gain ongoing media coverage for future reform campaigns?***

With few exceptions, the reporters interviewed cited the Illinois doctors' 1985 medical malpractice reform campaign as a model of medical spokesmanship and persuasion in the media. "I've never seen lawmakers 'roll over' as quickly as I did the day when I saw the medical society hold its lobbying effort," asserts WSSR Radio bureau chief Mary Frances Fagan. "And we ended up getting reams of information about exactly what the medical society's position was," she adds.

I have found that a lot of doctors are doing wonderful things that people would be amazed to find out. But they never think to call you . . .

With local physicians all over Illinois talking to legislators, media representatives and community leaders about the crisis, publicity was certain to follow. That constant stream of newsprint and broadcast tape played a part in keeping malpractice reform high on the public's and the legislature's collective agenda.

"I don't know exactly what role the media played, but I certainly can't think it hurt to have it so well publicized," notes WREX's Isham. "Especially the Springfield rally. We went there to actually take pictures of the whole thing," she recalls. "Because pictures have a much bigger impression on people than just words."

In 1985, however, the malpractice story was fresh, and unheard by many of Illinois' potential 11 million health care patients. Both media coverage and legislative persuasion are certain to pose a more difficult challenge in 1987. "Caps are tough to sell, particularly when we're talking medicine," cautions statehouse reporter Fagan. "There are going to be sad tales of woe, as opponents of your side wheel in victims of bad doctors," she predicts.

The media is likely to choose covering medical malpractice stories much more selectively in 1987. "From my point of view," states *Sun Times* reporter Wolinsky, "it's sort of 'what else is new?' In Florida, people talk about walk-outs, quitting their practices and so-on. Things may be just as bad up here, but you don't get that feeling from talking to doctors," he says. In addition, Wolinsky has found physicians reluctant to discuss retirement or other practice decisions related to the malpractice crisis. "Unless we can humanize some of these stories," he maintains, "it's hard to do them."



Amy Ragsdale is health and social services reporter for the Decatur Herald & Review.

Speaking from the perspective of a medical trade publication, Paul Gerber of *Physician's Management* seconds Wolinsky's opinion. "From the national level, malpractice has gotten to be 'that old discussion.' We still write about how to prevent it, how to maintain records, and how to give the ten point malpractice check-up to your office." Gerber calls these "evergreen stories."

Gerber believes that organized medicine's approach to publicizing the medical malpractice crisis—communicating it as a patient, rather than just a physician issue—has worked well. "The press can say that reform is just what it is—self-interest . . . that physicians are trying to make it our interest. What's wrong with that? It makes sense," he adds.

In Gerber's view, the problem of defining negligence in contrast to a bad outcome is a story which organized medicine should concentrate on telling more clearly. "You don't get clear answers from either side," he says.

Despite polls demonstrating that the American public is more attuned than ever before to the costs of medical malpractice, Dr. Bruce Dan of Chicago's WLS TV and *JAMA* doesn't believe the public really understands the problem. "They don't understand the difference between malpractice and professional liability . . . that society has to bear the cost of any event that happens to people, regardless of who is responsible." He advises Illinois physicians that "we need to do a much better job at telling patients that we need to overhaul the system to guarantee that everybody gets equitable treatment . . . That there are catastrophic health insurance plans to help people with tremendous medical bills." In sum, he suggests that "we must take the lead in establishing to our patients what they need to know so they can help us change the system for everybody's benefit."

IMJ: *In addition to petitioning the state legislature for additional medical malpractice reform, Illinois' medical profession will also be subject to scrutiny during review, and possible rewrite of the Medical Practice Act before its scheduled year-end 1987 sunset date. How can physicians best explain the importance of this legislative action to the media and patients?*



Bruce Dan is medical editor of Chicago's WLS Television and senior editor of JAMA.

Doctors need to improve their visibility as caretakers of the public health.

WSSR statehouse bureau chief Mary Frances Fagan asserts that "working on such complex stories, where you've got to do the right interview, get the right person to explain it and make sure that it makes sense," is the hardest part of her job. She advises local medical societies to start early by previewing for reporters "what is going to go on in Springfield and why it's important. It's going to be tricky," Fagan warns, "in that the Medical Practice Act review is not a single, individual story. Try to search out any conceivable way to make it a visual or an oral story," she recommends.

Local reporters, outside the ranks of the statehouse bureau, won't necessarily do this story on their own without some prompting, Fagan suggests. "Get to know the reporters and remind them about the Medical Practice Act. You will have to do some field work if you want your position heard loudly enough that it is also heard by lawmakers," she says.

IMJ: *What advice can you give physicians to boost their effectiveness in working with the media?*

Our journalists cited four recurring themes: eliminate medical jargon, get to the point quickly, speak authoritatively *only* about what you know, and be accessible. Following these basics helps both the reporter and the physician crystallize medical information for the audience, and lessens the risk of a distorted or confusing story.

But observing these seemingly simple guides can be exceedingly difficult for the inexperienced physician, attests Dr. Dan. "One skill they do not teach us in medical school is how to communicate with the public, even though that's our number one job. We've learned a special skill and we're supposed to report that to our patients . . . teach them about urinary tract infections, hypertension and strokes, cigarettes and alcohol, immunizations."

Dan suggests that physicians doing television interviews strive to "say succinctly the major point—the bottom line—in 15-20 seconds."

While the print media can usually provide more in-depth coverage on medical issues than television, *Sun Times* reporter Wolinsky also argues

. . . health care is such an interesting topic for people. If they're sick, they crave information about what's wrong with them. If they're not sick, they want to know about things that can keep them well.

What Makes a News Story Work?

IMJ asked six Illinois medical reporters their views on the essentials of a "good" story. Here's what they said . . .

Bruce Dan, M.D., WLS Television, Chicago and Journal of the American Medical Association:

The hardest thing I have to do is to try to convince the people I work for what is important and what is not. What's hyped. What isn't hyped. The most important job I do is the stories I tell them not to run . . .

. . . We doctors have to find a way of telling people what they need to know. People are not interested in our dissertations on grand rounds. They want to know the answer: "Should I take this medicine or not?" "Should I drink this contaminated milk?" "Should I wear a tampon or not?"

Mary Frances Fagan, WSSR Radio, Springfield:

The sound. As a radio reporter, if I were doing a story on a kidney machine, I'd have my microphone as close to that machine as possible to capture the sound.

. . . You have to use examples. You have to explain what legislation will mean to someone who is not in Springfield, who doesn't focus on what happens in the legislature every day. You have to break an issue down into palatable pieces. This will be difficult when we get to the Medical Practice Act rewrite. It's also going to be interesting!

Paul Gerber, Physician's Management:

Greed and fear are two criteria some magazines use to make a good story. But that's not necessarily the best way. You don't have to be scandalous by any means to have a healthy magazine. We try to provide quality, credible information that is well presented and well packaged. It's often built around the notion of "how-to"—instructional in nature. You can always find a doctor who will tell you something outrageous. We don't really deal with that anymore. It's too cheap.

. . . Really, writing leads is the whole trick to a good story.

Liz Isham, WREX Television, Rockford:

Something with human interest. People are always interested in what affects "me." Good visuals are especially important for TV news . . . for instance, from a clinic where testing is going on. We try to steer away from showing patients. But we like machinery.

. . . Medical stories generally get high viewer response. When I was weekend anchor and producer, and WREX ran health related stories on Saturday and Sunday, we received many, many calls on Monday morning.

Amy Ragsdale, Decatur Herald & Review:

First of all, I've got to make sure I have the health facts straight. I want an expert to talk to me. I have doubts when I hear a technical medical explanation coming from someone I know doesn't have any medical background. Readers feel much more secure hearing that kind of information from an M.D.

I also look for a local angle. In doing a series on AIDS, I searched for people locally who had experience in treating the disease or who had the disease. Because in a small community, you'll often hear, "Oh, that doesn't happen here." Part of my job is to let readers know that national issues we're hearing about aren't just things that happen outside the city limits.

Howard Wolinsky, Chicago Sun Times:

Something that is new, something that people don't know about, something that affects a lot of people. Also, we must follow up on previous stories, for instance on the interluken-2 killer cell therapy story from a year ago. Problems are starting to come up with it. You've got to keep track of what has run before. Otherwise, there is not continuity.

Another consideration is your reader. I think of my reader as a person commuting to work. They have to get their information fast, which makes it even harder when you're dealing with a technical medical subject.

A good story contains the truth and is helpful to people. If there's something on the negative side, we're not going to run away from it. The negative side and the positive side are all part of the truth, whatever the truth is. ◀

for directness and brevity. "All of our stories have to be in there fast and out fast. In medical reporting we're working against the fact that newspapers, at least this newspaper, have very short stories. Sometimes, you can spend half your space defining terms," he explains.

When a physician believes that the media has failed to tell the whole story adequately, WREX's Isham encourages doctors to "let us know. Often, we'll go back out and do a follow-up." She cites a recent two-part story on cataract surgery as an example: "One segment ran on a Sunday and there was to be a week's lag before the second would run. On Monday morning a doctor called to say 'I really don't think the surgical procedure is right. You're not telling the whole story.' Even though the second part was done, we ripped it apart to include his comments."

Statehouse bureau chief Fagan says translating jargon—medical, legal and legislative—into plain understandable English is often difficult, but essential to public understanding of medicine's message. "Structured verdicts, collateral source offsets, and the PPOs, HMOs, the 'alphabet soup' approach to medicine are difficult to explain so that everybody can understand it," she cautions.

As doctors endeavor to build media visibility, *Sun Times* reporter Wolinsky advises some measure of moderation. "Speak authoritatively only about what you are an authority on," he says, "and if you don't know about it yourself, don't claim that you do." Dr. Dan reiterates, "basically you just need to say 'I don't know.' That will stop you from getting into a lot of trouble."

On the final theme of accessibility, *Herald & Review* reporter Ragsdale encourages physicians to be freer in providing information. She laments she often has trouble finding physicians willing to comment on "nitty gritty issues" in the community. And often, she says, "I am given all sorts of wonderful answers about how a new health care program is going to help the community. But there's also a monetary factor involved, which I think a lot of people recognize." According to Ragsdale, "it's better to admit that factor, and explain it. In fact, if that's left out, it's usually the talk of the street the next day. Your patients are business people. They understand business."

Get to know the reporters and remind them about the Medical Practice Act. You will have to do some field work if you want your position heard loudly. . . .



Mary Frances Fagan is the statehouse bureau chief for WSSR, Springfield's public radio station.

Physician's Management reporter Gerber emphasizes the importance of prompt response to media inquiries. "It's beneficial for physicians to realize that reporters are no different than they—the only thing that counts is their time. We're not sitting around looking to write a story over three weeks. When we get an assignment, we typically have to turn it over." Gerber suggests that physicians who are unable to carve out time for an interview during their busy working hours, schedule it later by asking the reporter to call at home that night—"not two or three nights later."

To make medicine more accessible to the media, WSSR's Fagan advises county society presidents to establish contact with their local media representatives. "When I was a local reporter, it would have been very handy to have known who was there if I needed a doctor quickly to talk about a subject," she says.

Virtually all reporters noted some special restraints that physicians sometimes tie to their media accessibility. "Doctors, more than anyone else, ask if they can read copy before it appears in print," notes Ragsdale of the *Herald & Review.* Wolinsky adds, "they don't understand why we can't do that. There are logistical problems, censorship problems from the bosses' point of view."

IMJ: *How would you describe the public's image of physicians? Are there strengths we might capitalize upon? Are there weaknesses which need correction?*

Two of our journalists cited perhaps the most widely held public misperception about the medical profession. "A lot of doctors are

Caps are tough to sell, particularly when we're talking medicine.

not seen as humans," according to WREX reporter Isham. "They're seen as super machines." She adds that, "Of the doctors I've met, many of them are neat people. But I think a lot of people see them with fear."



Howard Wolinsky is the medical reporter for the Chicago Sun Times.

Decatur reporter Ragsdale agrees, but cautions that "sometimes the medical profession likes that image and wants to maintain it." She recalls two behind-the-scenes stories which showed that "doctors don't always know what's going on, that some decisions are made, not simply because it's best for the patient, but because of liability or legal concerns. I got feedback from the medical community saying they wished those things hadn't appeared." But Ragsdale maintains, "that was the real beauty of the piece. It did show people that doctors are human beings, who have doubts and fears."

Two journalists addressed the public perception, specifically of organized medicine, and its clout in the legislative and political arena. Said *Physician's Management* reporter Gerber, "It's good to start with a healthy skepticism of your topic . . . and that's easy to do with organized medicine." He maintains that, "looking at the history of organized medicine, it has tried to stop every social program that has been initiated."

Gerber sees similarities in the perception of organized medicine by the public and by younger physicians. "Now, organized medicine is trying to open those doors and bring young physicians in," Gerber continues. "All of that is beneficial. It gets away from the image of being the 'old docs' who have made it."

Gerber admits his respect for organized medicine's activities has grown significantly since he began to cover the field. He asserts "there are so many good things on the clinical side," which organized medicine fails to get credit for, although it is published in their journals.

Statehouse bureau chief Fagan comments on medicine's image on state legislative issues. "What we saw happen with the 1985 Malpractice Act showed the strength of this issue," she says. But a more negative perception emerged when the Society introduced changes in the Medical Practice Act rewrite one year before its scheduled legislative review. Fagan remembers legislative reporters saying, "I can't believe the audacity of the medical society." Fagan doesn't think the intended strategy was "a last minute effort to ram something down their (legislators') throats. It was just the way the timing was perceived."

The "medical-industrial complex" is how Dr. Bruce Dan characterizes the public's image of medicine today. "The image the American public has of the physician," he laments, "is a dedicated businessman." Dan suggests that medicine needs to get back to "the days when doctors had little black bags and visited people in their homes to take care of them. They were doctors, not people interested in DRGs and medical clinics."

Dan argues that "physicians can make a good living in this country and still spend time with patients. When called at 9:00 at night, instead of saying, 'go to the emergency room and someone will take care of you,' go see the patient yourself. Many physicians will say that's not possible nowadays. I'll argue that it still is."

In the final analysis, there is no substitute for performance in improving the image of the medical profession. As Wolinsky of the *Sun Times* sums up, "I'd say the best thing to do about your image is not to set out with a big public relations campaign to smooth off the rough edges; the best thing to do is just for



Elizabeth Isham is a general assignment reporter for WREX Television in Rockford.

. . . the best thing to do about your image is not to set out with a big public relations campaign to smooth off the rough edges; the best thing to do is just for each physician in his own practice to think about what he's doing.



Paul Gerber is senior contributing editor for Physician's Management.

There are so many different levels of stripes and currents within medicine between all the specialties. As a reporter, there's a whole subculture you need to get involved with.

each physician in his own practice to think about what he's doing." Wolinsky suggests that doctors think about "little things that mean a lot to patients—how long is the patient waiting; do you explain to the patient why it took so long to get in; do you overbook?"

The family doctor, the guy with the corner office is really going out. He's being replaced by big corporations. How is the public going to fit in?

IMJ: *What current or emerging issues do you see playing a big part in future medical news stories?*

Our journalists outlined a variety of trends which will, or are already affecting health care providers and patients in Illinois.

From the clinical side, Rockford reporter Isham expects a growing interest in head injury and head trauma. She also notes current socioeconomic pressures leading to "super clinics—and their affiliations with various university hospitals." She warns that "the family doctor, the guy with the corner office, is really going out. He's being replaced by big corporations." And she asks, "How is the public going to fit in?"

Isham also predicts even more problems associated with government spending on Medicare as the baby boom becomes the "elderly boom." She queries, "What are we going to do with all these people?"

Income is what everyone will be focusing on in future years, according to *Physician's Management* reporter Gerber. "You have people now saying that doctors are going to have parity with dentists, podiatrists, optometrists," Gerber notes. "I can't imagine it would happen. A lot of people suggest that it shouldn't happen. But medicine is going to take the full force of social changes dealing with cost containment," he predicts.

One important public health issue already upon both organized medicine and the general public is smoking. *Sun Times* reporter Wolinsky characterizes the ISMS House of Delegates as "on the cutting edge" when in 1986 it took a position on ownership of tobacco stocks by universities. "I think it's important for doctors to put themselves up front on it," he says, "because it shows they are doing something on behalf of their patients. It's not a selfish economic position."

According to WLS TV's Dr. Dan, recent polls show, "the biggest concern among American people right now about health is drugs like cocaine and heroin, which are, on the order of magnitude, less of a problem than alcohol and tobacco. Alcohol is responsible for 100,000 deaths per year. Tobacco kills 1,000 people a day in this country," Dan adds. "Those are the real problems."

As medical reporting becomes more sophisticated and more popular, the collective advice of these journalists can provide invaluable guidance for doctors getting active in the public media. All of the six, like their colleagues throughout Illinois, would like to hear more from physicians on key public health issues. Paul Gerber of *Physician's Management* sums up the challenge these reporters face in covering the ever-broadening medical news beat: "There are so many different levels of stripes and currents within medicine between all the specialties. As a reporter, there's a whole subculture you need to get involved with."

That's where physicians play a role as sources and spokesmen on medical issues. According to Dr. Dan, "the best people to tell the public about a medical problem are doctors. Let it come from the 'horse's mouth.' "

Meet the Media Interviewed by IMJ . . .

Bruce Dan, M.D., is medical editor of Chicago's WLS Television and senior editor of the *Journal of the American Medical Association.* Two-and-a-half years ago, he began doing twice weekly medical stories for Chicago television news. "When there's breaking medical news, like salmonella in milk and the President's colon cancer, it becomes five days a week at 4, 5, 6, and 10 p.m.," he explains.

A graduate of MIT's astronomical engineering program, Dan worked for NASA "for a couple of years" before going to medical school at Vanderbilt University. He did his internship and residency in internal medicine and completed post-doctoral fellowships in computerized medicine and infectious disease.

Before coming to Chicago, Dan was an epidemic intelligence service officer at the Centers for Disease Control, and served as deputy chief of the Toxic Shock Syndrome Task Force. In 1983, Dan was Morris Fishbein Fellow in medical journalism. Here in Chicago, he can usually be found at *JAMA* offices, WLS TV or somewhere in between.

Mary Frances Fagan is the statehouse bureau chief for WSSR, Springfield's public radio station. Fagan's beat is the state legislature and state government. She joined WSSR five years ago, after working in commercial radio and television in Moline, Bloomington and Champaign. She completed her undergraduate degree and received a masters from Sangamon State University, Springfield.

Fagan is attuned to medical issues from growing up in a medical family. "My dad was an OB/GYN in Champaign. My mom is an RN. I know what it's like having your phone ring at all hours of the night."

Paul Gerber is senior contributing editor for *Physician's Management,* where he has covered socioeconomic medical matters since 1979. The monthly magazine has a 110,000 circulation of mostly primary care specialists. Gerber is also contributing editor of *Ophthalmology Times,* and a consulting editor for *Dental Management.* He began his journalism career as an investigative reporter intern for the St. Louis *Post Dispatch.*

After receiving his undergraduate degree from Washington University in St. Louis, Gerber continued his studies there, earning a Masters of Juridical Studies from the University's law school. "My master's thesis was on 'Witness Intimidation in Medical Malpractice Cases,'" he notes. "That's one of the reasons I've spent so much time dealing with malpractice cases. It's perhaps the most interesting field you could imagine to report on."

Elizabeth Isham of WREX Television in Rockford was a premed student for two years before deciding to steer her course of study instead toward a journalism career. Currently a general assignment reporter, she develops "health watch" segments twice weekly and handles the station's medical news. Before joining WREX, Isham was an investigative reporter and assistant city editor at the *Daily Iowan* in Iowa City. She also was television and radio bureau chief for KGAM in Cedar Rapids, covering the southern third of the state.

Isham graduated from the University of Iowa. "I was introduced to medical news because Iowa City is the home of the largest teaching hospital in the United States," she recalls. Isham also grew up in a medical family, where medicine was discussed "at the dinner table. It's an interest I've always had," she says.

Amy Ragsdale, health and social services reporter for the Decatur *Herald & Review,* has been a journalist for two-and-a-half years. She began her career at the *Daily Times Courier* in Charleston, Illinois, where she was an area reporter. In her current position, Ragsdale covers about 75 agencies, "that include both of the city's hospitals, mental health services, rehabilitation services, and services for the elderly and handicapped."

Ragsdale has a graduate degree in journalism from the University of Illinois at Urbana-Champaign. She specialized in health writing there.

Ragsdale expresses excitement about covering the ever-growing field of health care, and looks forward to developing a close working relationship with Decatur's medical community. "I've been here a year," she says, "and it's just now getting to the point that they are opening up because they know me."

Howard Wolinsky has been the medical reporter for the Chicago *Sun Times* for the last five-and-a-half years. He has worked for daily newspapers since 1970, starting with the *Kankakee Journal,* where he covered mental health. Wolinsky also wrote for the St. Petersburg *Times* in Florida. It was there he experienced the first rumblings of the medical malpractice crisis. He also spent one year as a reporter for the *American Medical News.*

In addition to receiving a masters degree in journalism from the University of Illinois at Urbana-Champaign, Wolinsky completed a fellowship at the University of Michigan. There, he studied "political economy, sociology, anthropology, ethics and probably a few other things."

"At the *Sun Times,*" Wolinsky tells, "not only am I supposed to keep track of what goes on in Chicago, but I have to keep an eye on what's going on elsewhere in the country, or even the world."

OBITUARIES

****Bennett, Granville A.,** Union City, Michigan (formerly of Chicago), died November 25, 1986 at the age of 85. Dr. Bennett was a 1925 graduate of the University of Iowa College of Medicine, Iowa City.

***Fishkin, Martin,** Skokie, died December 28, 1986 at the age of 71. Dr. Fishkin was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

****Kolter, Bernard C.,** Chicago, died December 22, 1986 at the age of 88. Dr. Kolter was a 1925 graduate of the Loyola University Stritch School of Medicine, Maywood.

Levine, Maurice, Morton Grove, died December 26, 1986 at the age of 85. Dr. Levine was a 1923 graduate of the Delhousie University Faculty of Medicine, Halifax, Nova Scotia, Canada.

****Mark, Samuel J.,** Chicago, died December 16, 1986 at the age of 83. Dr. Mark was a 1929 graduate of Northwestern University Medical School, Chicago.

****Nelson, Charles A.,** Pekin, died November 22, 1986 at the age of 76. Dr. Nelson was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

***Peach, Richard O.,** Olney, died December 6, 1986 at the age of 64. Dr. Peach was a 1954 graduate of the McGill University Faculty of Medicine, Montreal, Quebec, Canada.

Tucker, Gabriel F., Jr., Chicago, died December 8, 1986 at the age of 62. Dr. Tucker was a 1951 graduate of the Johns Hopkins University School of Medicine, Baltimore.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Jacob E. Reisch, M.D., ISMS Honorary Past President and Past Secretary-Treasurer

Jacob E. Reisch, M.D., an ISMS honorary past president and past secretary-treasurer, died December 11, 1986 at the age of 82.

A 1929 graduate of the University of Illinois College of Medicine, Dr. Reisch served the Society for many years beginning in 1947. He was voted honorary president in 1979, the only physician ever to receive this award. Dr. Reisch, a former ISMS trustee and delegate to the AMA, also served as ISMS secretary-treasurer from 1960 to 1977, and was chairman of the Publications Committee from 1956 to 1977. He also was a member of the ISMS Fifty Year Club.

Dr. Reisch was active in medical writing as well, and was president of the American Medical Writers Association in 1953. In addition, for many years, Dr. Reisch was editor of both the *Sangamon County Medical Society Bulletin* and the *Phi Chi Medical Fraternity Quarterly.*

A native of Springfield, Dr. Reisch served as president of the Sangamon County Medical Society in 1964. He was president of the Memorial Hospital's medical staff from 1958-59.

Perry L. Smithers Long-Term ISMS Employee

Services were conducted for Perry L. Smithers, who died Friday, January 23, 1987. Mr. Smithers began work with the Illinois State Medical Society in 1965 following previous employment at the University of Illinois, the Folding Paper Box Association and Ravenswood Hospital. He was a graduate of the University of Illinois and served in the U.S. Army in World War II, having been discharged in 1946.

Mr. Smithers was involved with staffing various councils and committees of the Illinois State Medical Society over the years, including service with the *Illinois Medical Journal.* Most recently, he had been responsible for the Educational & Scientific Foundation, including the Student Loan Fund, as well as the Benevolence Fund administration.

He is survived by his wife, Mickey, two daughters, Darragh and Storme, his son, Stephen, and a brother. Memorials for Mr. Smithers can be made to the American Heart Association and the Illinois State Medical Society Benevolence Fund.

Volunteers Recruit Members

ISMS wishes to recognize volunteer members who participated in two programs designed to increase ISMS membership in 1986. These programs, the Telephone Retention "Phonathon" and ISMS Outreach, resulted in the addition of 16 new members and the renewal of 53 members.

Phonathon

Eleven physicians volunteered to telephone members who had not paid their 1986 dues. Twenty-nine percent of members contacted in this retention program agreed to renew their membership for another year.

The following physicians participated in this event:
Thomas R. Harwood, Chicago
William J. Marshall, Olympia Fields
Pedro A. Poma, Melrose Park
William J. Tansey, Downers Grove
John W. Mason, Hinsdale
David B. Littman, Highland Park
Marshall Short, Chicago
Cyril C. Wiggishoff, Chicago
Thomas P. Meirink, Belleville
Michael C. Snyder, Springfield
M. LeRoy Sprang, Skokie

ISMS Outreach Program

Thirteen physician volunteers participated in a contest to increase membership held at the ISMS 1986 Annual Meeting, April 4-5. Albino T. Bismonte, M.D., was the first prize winner, adding four new members to the Society.

Participants of the Outreach Program in addition to Dr. Bismonte were:
David B. Littman, Highland Park
Marshall Short, Chicago
Joseph L. Murphy, Chicago
Robert Chesser, Rock Island
Jane Jackman, Springfield
Edward K. DuVivier, Alton
Allan L. Goslin, Streator
Fred Z. White, Chillicothe
Charles Downing, Decatur
August Rossetti, McHenry
Edward Warren, Danville
William Hays, Herrin

The American Medical Association also conducts an Outreach Program through its House of Delegates. Albino T. Bismonte and Allan L. Goslin were both participants and prize winners at the AMA Interim Meeting in December, 1986.



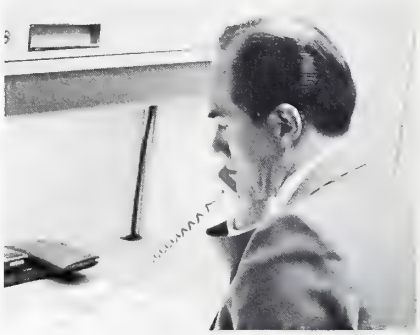
William J. Tansey, M.D., participated in the Phonathon in an effort to renew membership.



Albino T. Bismonte, M.D., winner of the ISMS Outreach Program and a winner in the AMA Outreach Program.



William J. Marshall, M.D., one of eleven Phonathon volunteers.

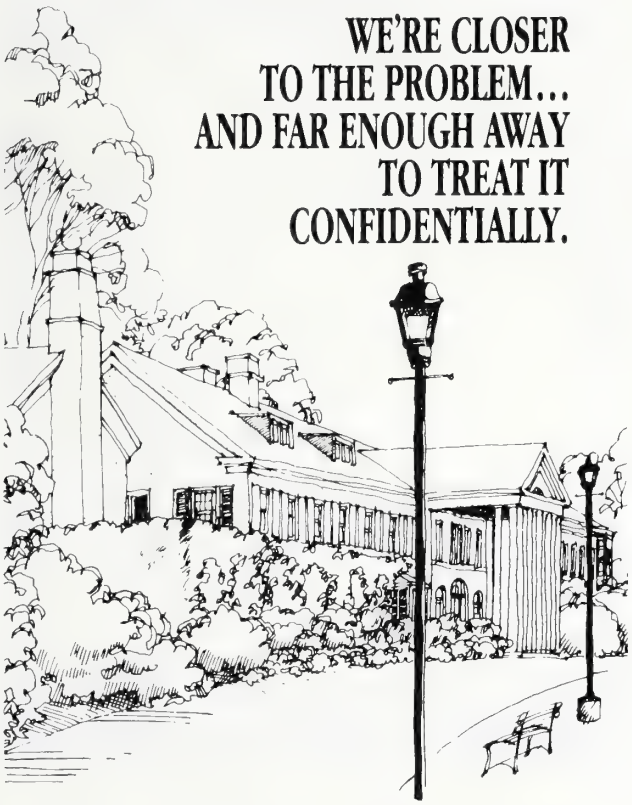


Pedro A. Poma, M.D., shown here in the 1985 Phonathon, was one of eleven physicians participating in the 1986 Phonathon.



Allan L. Goslin, M.D., was one of the American Medical Association's Outreach Program prize winners.

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For more information, or to discuss a specific case, contact:

Herb Trace, M.D.
Medical Director, Illinois Office
708 Church Street, Suite 259
Evanston, Ill 60201• (312) 492-1110

MILWAUKEE PSYCHIATRIC HOSPITAL
Roland Herrington, M.D., Director
Division of Chemical Dependency (414) 258-2600

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—to join an established four member group of general internists in Bloomington-Normal, Illinois. Complete office facilities. Midwestern University community with strong economic base. Contact: Judy Buchanan, Administrative Director, The Health Center, 702 North East Street, Bloomington, 61701, AC 309-827-5051. (6)

GIBSON CITY:
Opportunities for Family Practice and Internal Medicine either in partnership with a family practitioner or in solo practice. Fully equipped office facility and income support arrangements available. Stable farm community serving 20,000 population within a 20 mile radius. 30 miles north of Champaign-Urbana. Three hour drive south of Chicago. Contact: Terry Thompson, Administrator, Gibson Community Hospital, 1120 North Melvin Street, Gibson City 60936, (217) 784-4251. (4)

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

GRAYVILLE:
On Interstate 64, population 3,000 64,000 medical market area. New completely furnished medical clinic facility. Financial package, twenty minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: Rebecca S. Alcorn, 320 S. Second Street, Grayville, 62844 or call (618) 375-2171 weekdays and (618) 375-3431 evenings and weekends. (6)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St Louis. Average 30 miles from Springfield. Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MOUNT CARMEL:
Orthopedic Surgeon, Pediatrician and Family Practioner—Population 10,000. 64 bed JCAH accredited general hospital, HCA managed, newly built in 1983 replacing a well-established older hospital. Good secondary and high-school and junior college. First year guarantee and other excellent fringe benefits, a lovely river city with several large thriving industries. Any cultural or recreational benefits not provided here are available in nearby large city. Contact: William S. Vokonas, Administrator; Wabash General Hospital, 1418 College Drive, Mt. Carmel, 62863, or phone (618) 262-8621, extension 300. (1)

PEKIN:
Opened new 20-office multi-specialty physician's medical center attached to Pekin Memorial Hospital, a 202-bed progressive community hospital. Competitive income guarantee and relocation allowance available. Contact: Ruth Campbell, Court and 14th Streets, Pekin, 61554. (1)

PITTSFIELD:
Illini Community Hospital. Practice opportunities for FP, OB/GYN, Internist and Pediatrician; solo or partnership. Office space and financial assistance available. Service area 25,000. Excellent outdoor recreation. Close to St. Louis and Springfield. Good school systems, including colleges and universities. Contact: Kathleen Wegener, 640 W. Washington, Pittsfield, 62363. (217) 285-2113. (2)

SYCAMORE:
Internist with subspecialty interest in rheumatology to join a well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, 60178. (1)

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April 27-May 1, 1987
Specialty Review in Anesthesiology
May 10-15, 1987
Microneurosurgery
May 16-20, 1987
Advances in Internal Medicine
May 18-21, 1987
Specialty Review in Pediatric Hematology/Oncology
May 27-29, 1987
Specialty Review in Family Medicine
May 31-June 6, 1987
Specialty Review in Pediatric Cardiology
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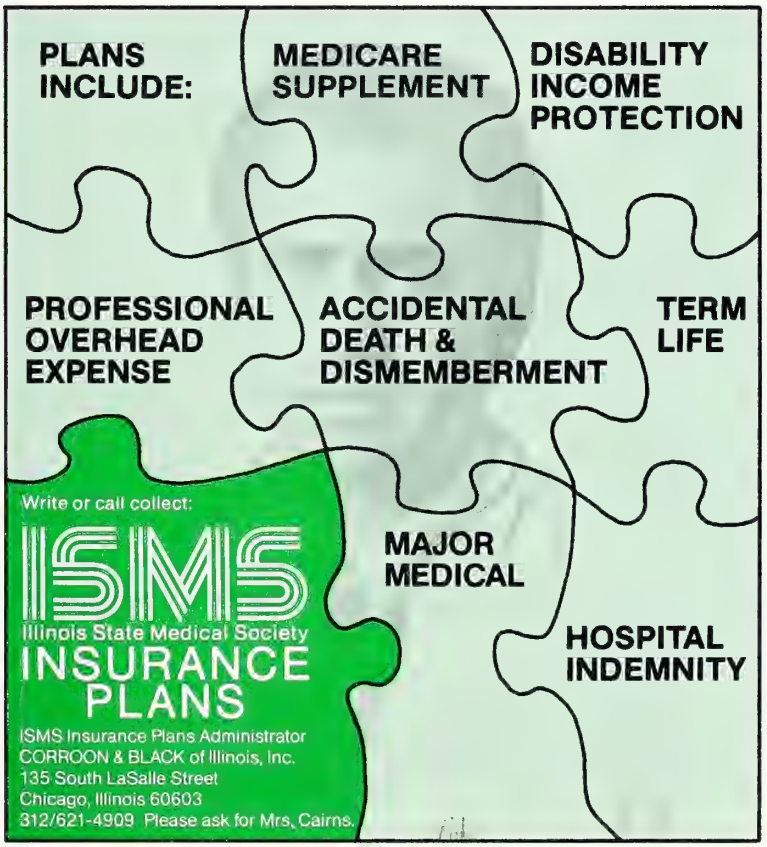
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Certification for Medical Assistants

By Catherine M. Hill, CMA, and Robin Bluestein, CMA-C/Palatine and Chicago

The credentials "Certified Medical Assistant (CMA)" indicate to employers, co-workers and patients competency in the medical assisting profession.

Certification, through nationally-recognized credentials, demonstrates that medical assistants are qualified and skilled members of the allied health team. It increases career potential by showing professional commitment and the ability to take on added responsibility, and prepares medical assistants for the future with increased job security and salary benefits. The certified medical assistant is recognized anywhere in the country, providing geographic and career mobility.

Presently, the American Association of Medical Assistants (AAMA) and its Certifying Board recommend voluntary recertification every five years. However, to remain current, all CMA credentials earned prior to 1988 must be recertified by January 1, 1993.

Recertification identifies those medical assistants who continue to demonstrate competency, and provides them an opportunity to maintain a professional identity. Two methods used for recertification are continuing education and examinations.

An examination will be offered in June 1987, and, beginning in 1988, examinations will be offered in January and June of each year. Deadline for applying for the January examination is October 15 of the previous year, while the June examination deadline is March 15.

All specialty, administrative, clinical, and/or pediatric credentials can no longer be earned. CMAs with any of these credentials can maintain them through the continuing education method only.

Many opportunities exist for certified medical assistants to obtain credit through continuing education.

The AAMA (national level) offers a variety of guided study programs. The Continuing Education Board, in conjunction with the AAMA, is in the process of developing new programs. Also, the AAMA publication, *The Professional Medical Assistant,* provides continuing education articles and information.

Continuing education programs are offered at the state level by the Illinois Society of Medical Assistants (ISMA) through its annual convention, symposium, clinical conference, and travel course.

Many local chapters offer continuing education credit at monthly meetings. One possible method may be recertification in cardiopulmonary resuscitation and/or first aid.

All programs offered at the national, state, or local level are reviewed by the Continuing Education Board of the AAMA prior to offering continuing education units to certified medical assistants.

To obtain information regarding certification and/or recertification (including an application, sample worksheet and detailed requirements), please write the American Association of Medical Assistants, Department of Certification, 20 North Wacker Drive, Suite 1575, Chicago, Illinois 60606.

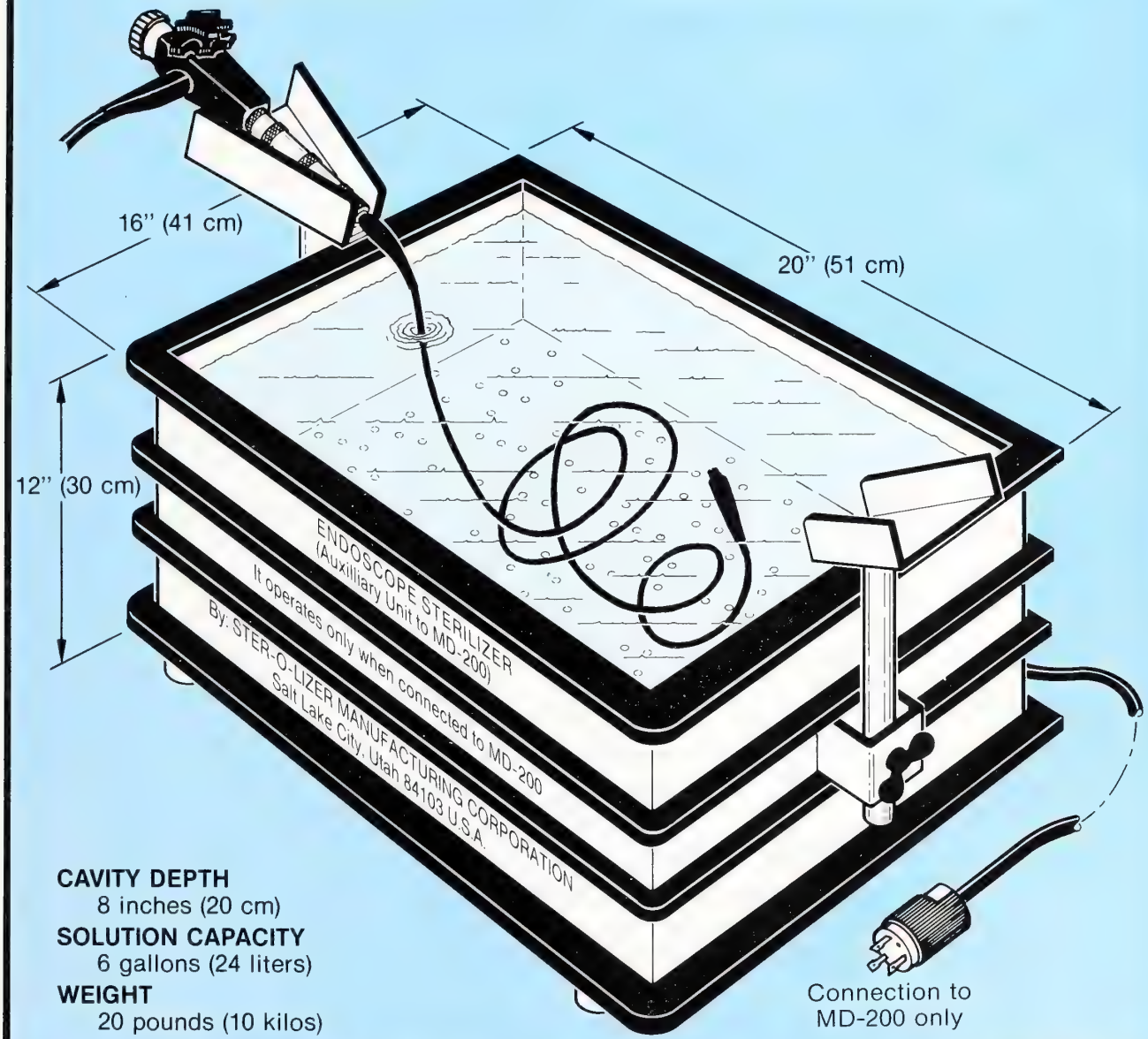
Information regarding the Illinois Society can be obtained from Mary Lu Ostrowski, CMA; 1704 East Jackson Street, Bloomington 61701; Robin Bluestein, CMA-C, co-chairman, public relations committee, 2247 West Estes, #2, Chicago 60645; Catherine M. Hill, CMA, co-chairman, public relations committee, 900 South Plum Grove Road, Palatine 60067. ◀

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January 1987

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MARCH

Clinical

43rd Annual Midwest Clinical Conference
For: Physicians of all specialties, March 6-8, Chicago. **Sponsors:** Chicago Medical Society, 515 N. Dearborn, Chicago, IL 60610, and 40 contributing specialty societies. **Fee:** Pending. **Reg. Limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Christine Ricker. **Phone:** (312) 670-2550, Ext. 254.

Sports Medicine

Third Annual Sports Medicine Conference
For: Physicians. Symposium, March 14, Rockford. **Sponsors:** University of Illinois College of Medicine at Rockford, Department of Community Medicine, Rock River Chapter of the American Red Cross, Rockford Memorial Hospital, St. Anthony Medical Center, Swedish-American Hospital, and the University of Illinois Medical Alumni Association. **Fee:** $20. **Reg. Limit:** None. **Credit:** Category 1: 8 hours. **Contact:** Office of Continuing Education, University of Illinois, College of Medicine, 1601 Parkview Avenue, Rockford, IL 61107. **Phone:** (815) 987-7140.

Pathology

General Concepts of Graft vs. Host Reaction
Pathology of the Liver Related to Transplantation
Pathology of Heart Transplantation
For: Pathologists. Lecture, March 16, Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Diabetes

The Diabetic: Preserving the Quality and Quantity of Life
For: Physicians. Symposium, March 21, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $20. **Reg. Limit:** None. **Credit:** Category 1: 6.25 hours; AAFP Prescribed: 6.25 hours; and ADA: 6.25 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Family Medicine

Perspectives in Primary Care
For: Primary care physicians, internists and other interested health care providers. Seminar, March 27-28, Chancellor Inn, Champaign, IL. **Sponsor:** University of Illinois College of Medicine, Urbana-Champaign, Department of Family Practice, Urbana. **Fee:** 150. **Reg. Limit:** None. **Credit:** Category 1: 14 hours; AAFP Prescribed: 14 hours. **Contact:** Deborah C. Rugg, Carle Foundation Hospital, 611 W. Park Street, Urbana, IL 61801. **Phone:** (217) 337-3022.

APRIL

Pathology

T-Cell Lymphomas
For: Pathologists. Lecture, April 13, Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Orthopedic Surgery

Surgery of the Spine: State of the Art
For: Orthopedic and neurological surgeons. Symposium, April 29-May 2, St. Louis, MO. **Sponsors:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104 and Cardinal Glennon Childrens Hospital. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 24 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Ophthalmology

11th Annual Ophthalmology Current Concepts Seminar '87
For: Ophthalmologists and ophthalmologic nurses. Conference, April 2-4, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, and Department of Ophthalmology, School of Medicine, University of Wisconsin. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 18 hours and University of Wisconsin CEUs: 18 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Cancer

Lymphoma and Biological Response Modifiers
For: Physicians. Symposium, April 10, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $20. **Reg. Limit:** 200. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; and ADA: 6 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

OB-GYN

14th Annual Symposium on Obstetrics and Gynecology
For: Physicians. Symposium, April 23-24, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $200. **Reg. Limit:** 200. **Credit:** Category 1: 13.25 hours; AAFP Prescribed: 13.25 hours; ADA: 13.25 hours; and ACOG: 13 cognates. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Cardiology/Internal Medicine/Family Medicine

Primary and Secondary Prevention of Heart Disease: Making the Right Decisions.
For: Physicians and allied health personnel. Symposium, April 29-May 1, Milwaukee, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, and Cardiovascular Disease Center, University of Wisconsin-Milwaukee Clinical Campus, and Mt. Sinai Medical Center, Milwaukee, WI. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 15 hours and University of Wisconsin CEUs: 15 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

May

Neuroradiology

1987 Neuroradiology Review Course
For: General radiologists, neuroradiologists, neurosurgeons, neurologists, and residents. Course, May 2-3, Oakbrook Marriott Hotel, Oak Brook, IL. **Sponsor:** Loyola University Medical Center, 2160 South First Avenue, Maywood, IL 60153. **Fee:** $170 for physicians and $100 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3237.

Illinois State Medical Society
Illinois State Medical Society Auxiliary

4th Annual Medical Student Loan Fund Raffle

Grand Prize: Personal Computer with Printer

Drawing to be held at the ISMS Annual Meeting April 9-12

Other Prizes to be Announced

Tickets will be mailed to all ISMS/ISMSA members

All Proceeds will benefit the ISMS Medical Student Loan Fund

In mild to moderate hypertension

Brief Summary

THE FIRST ONCE DAILY CALCIUM CHANNEL BLOCKER

ISOPTIN® SR
(verapamil HCl/Knoll)
240 mg scored, sustained-release tablets

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDOSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVERDOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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"I Quit Clinics"

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

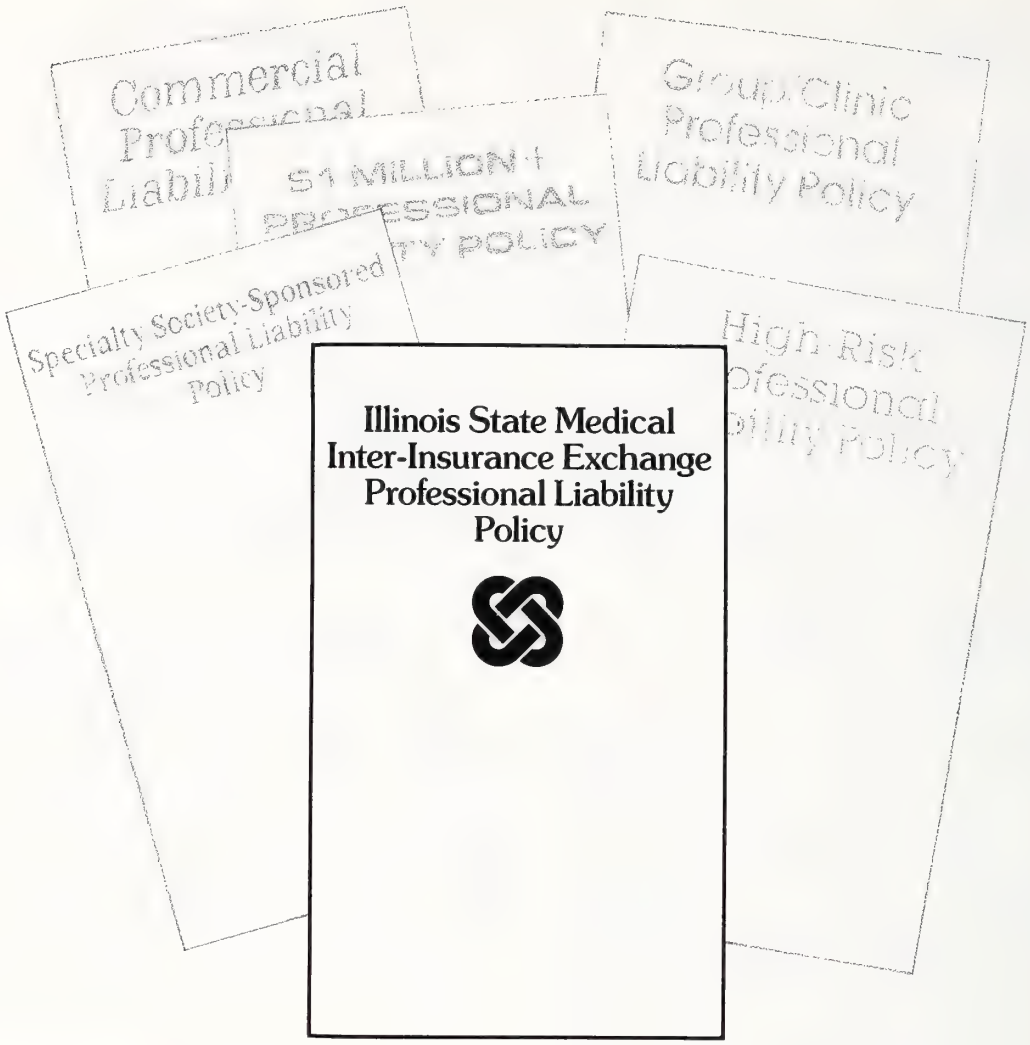
Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

March 3	Skokie Valley Hospital	*Skokie*
March 4	Lakeview Mental Health Center	*Chicago*
March 15	Victory Memorial Hospital	*Waukegan*
May 12	St. Theresa Medical Center	*Waukegan*
May 18	Condell Memorial Hospital	*Libertyville*
To Be Announced	Hinsdale Sanitarium and Hospital	*Hinsdale*
To Be Announced	Resurrection Hospital	*Chicago*
To Be Announced	West Town Public Health Clinic	*Chicago*



A disappearing act?

The number and size of damage claims against physicians continues to rise. And it's drying up most sources of malpractice insurance for Illinois doctors.

But there's one company that will still be here even if all the others are gone. The Illinois State Medical Inter-Insurance Exchange.

The Exchange is a company owned and operated by its policyholders. As such, we put our policyholders ahead of profit.

Unfortunately, the Exchange is not immune from the ravages of the current legal situation. The shrinking availability of backup insurance protection is forcing us to offer only claims-made policies after July 1.

But even with claims-made, we intend to make sure that Exchange policyholders will continue to have the best professional liability protection available. The same aggressive defense of frivolous suits. And programs to help you avoid the incidents that can lead to malpractice suits.

The Illinois State Medical Inter-Insurance Exchange. There when you need it.

Illinois State Medical Inter-Insurance Exchange
Twenty North Michigan Avenue
Suite 700
Chicago, Illinois 60602
(312) 782-2749 800-782-ISMS (Toll-Free

EKG

(Continued from page 60)

Answers: 1 B. 2. A, B, C, D, E

The ECG rhythm strip showed a wide QRS tachycardia at a rate of 150 beats per minute. During the recording, the patient bent over and held his breath. This converted the tachycardia to normal sinus rhythm. The QRS morphology of the tachycardia is similar to the QRS of normal sinus rhythm and is compatible with complete right bundle branch block. If the RR cycles to the left of the top strip are measured, they are found to be slightly shorter than the RR cycles in the middle strip. This lengthening of the RR cycles just prior to conversion to sinus rhythm suggests a vagal mechanism reducing the conduction velocity of the atrioventricular nodal (AVN) reentry tracts. In contrast, vagal mechanisms would have no effect on ventricular tachycardia, atrial fibrillation, or atrial flutter. An increase in AVN block might allow atrial fibrillation or atrial flutter to be better seen. No P waves were seen during this tachycardia.

This is paroxysmal supraventricular tachycardia in a patient with complete right bundle branch block and a history of myocardial infarction. No angina, dyspnea, or lightheadedness was ever associated with the tachycardia. Hyperthyroidism, myocarditis, pericarditis, mitral valve prolapse, and preexcitation were all excluded in our patient. Coffee, tea, cola, and cigarette smoking were eliminated.

Essentially, all the answers in question two are reasonable. An electrophysiology study could have confirmed the diagnosis of supraventricular AVN reentry tachycardia. It could have eliminated the diagnoses of atrial, junctional, sinoatrial nodal tachycardia, as well as concealed bypass tracts. This study could also have directed drug testing. In our patient many drugs had been tried without good results. Moreover, since he was experiencing many episodes, any useful drug could soon be identified because the incidence of tachycardia would promptly decrease.

Some assessment of the patient's coronary heart disease would be worthwhile. Because no angina or other complications were evident since the myocardial infarction, an exercise thallium test might have sufficed. In the absence of symptoms, coronary angiography could have been deferred. Our patient was afraid of the treadmill, so a testing radionuclide angiogram was done. At rest, the left ventricular ejection fraction was 32% with apical inferior hypokinesia. After some drug testing with ECG monitoring, the best treatment plan was determined to be digoxin and verapamil. Digoxin and verapamil interact causing an elevation in the serum digoxin level. The serum digoxin level was monitored. The combination of digoxin and verapamil gave 85%-90% control of the supraventricular tachycardia. ◀

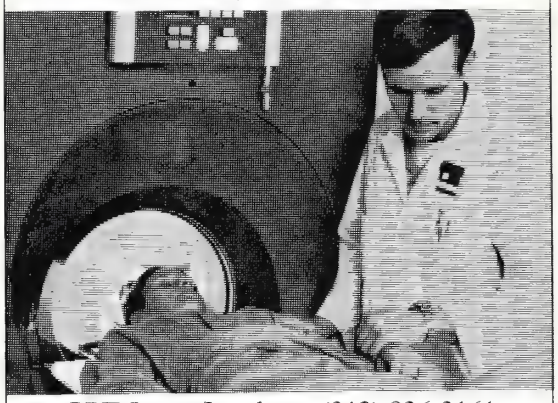
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ISMS Physician Help Line

Are you troubled by chemical dependency, alcoholism, physical or mental problems, or concerned about someone who has an impairment? Are you having problems dealing with your involvement in a malpractice suit?

If so, contact the PHYSICIAN HELP LINE, 312/580-2499, a confidential, advocacy service offered by the ISMS Impaired Physician Program and the Physician Support Group to link troubled physicians and their families with resources to help them.

The Physician Help Line is open 24 hours, 7 days a week. Calls will be answered as soon as possible, and information is shared only with the physicians helping the person who calls.

PHYSICIAN
Editorial Consultant

The American Medical Association seeks the consulting services of a Physician to work on-premise on a contractual basis, approximately 15 hours per week.

Consultant will assume responsibility for the writing/editing of materials related to current medical/surgical procedures. Will perform functions including, but not limited to, in-depth analysis of medical/surgical procedures based on current medical literature and proven clinical experience; developing editorial panel agenda items; and responding to selected physician inquiries. Prefer Physician with general surgery background and proven writing skills.

Those expressing interest should respond with synopsis of qualifications to:

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All proposed advertisements should be received by the first of the month preceding publication. A surcharge of $5 will be assessed when a box number is requested and an additional 18 words should be added in calculating the advertising rate.

POSITIONS AND PRACTICE

ARIZONA BASED Physician recruitment firm has opportunities coast to coast. "Professionals working with Professionals." Over 14 years experience. Call (602) 990-8080; or send CV to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252.

WELL ESTABLISHED PRACTICE for sale. General practice and general surgery. Chicago suburb. Will introduce up to one year. Grossing over $200,000. Reply to Box #2006, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SURGEON: Looking for associate in the established practice of general surgery. Suburb of Chicago. May eventually buy in one year. Reply to Box #2007, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

IMMEDIATELY NEEDED: Family practice/ internist. Guaranteed $35/ hour plus percentage. Close to St. Louis. Hospital privileges: community and St. Louis. Call (618) 254-7478.

IMMEDIATE OPENING full-time emergency physician at trauma center southwest of Chicago. Considerable exposure to acute trauma. Partnership within one year, remuneration exceeding six figures. Must be board certified in internal medicine, or at least two/three years experience in emergency medicine. Contact W. L. Gordon, (815) 744-2800.

PRIMARY CARE PHYSICIANS—Arizona based physician recruitment firm has various opportunities for BC/BE OB/GYN, FP, pediatric physicians coast to coast. For further information, call Mitch Young at (602) 990-8080; or send C.V. to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252.

HEALTHLINE PHYSICIAN SERVICES, An affiliate of St. Louis University Medical Center, has part-time and full-time opportunities available for physicians in emergency department, clinic and locum tenens work. Excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman at Healthline Physician Services, 8401 Hanley Industrial Ct., St. Louis, MO 63144.

PEDIATRICIAN TO JOIN well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, IL 60178.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has full-time private practice opportunities for the following specialties: board eligible or board certified internal medicine, and board certified family practice, pediatrics and OB-GYN. Positions include income guarantee and no capital investment. For more information, contact Barry Trautman, 8401 Hanley Industrial Ct., St. Louis, MO 63144, (314) 962-1233.

MINNEAPOLIS—Family practice, internal medicine, cardiology, child psychiatry, adult psychiatry, obstetrics/gynecology, ophthalmology, urology. Join established group in one of America's leading metropolitan areas. Group provides professional liability, four weeks vacation, two weeks conference leave, disability, retirement, hospital dues and more. Must be board certified or board eligible. Direct inquiries to: Paul J. Brat, M.D., Medical Director, Group Health, Inc.; 2829 University Ave. S.E., Minneapolis, MN 55414.

EMERGENCY PHYSICIANS NEEDED, Chicago, Illinois. Full or part time. Prefer board certified in emergency medicine or board eligible, or at least three years full time experience. New contractual situation with new group will offer outstanding growth possibilities and excellent compensation. Take advantage of this exciting opportunity to live and work in dynamic Chicago. Send resume as soon as possible to Medical Director, 666 Lake Shore Drive, Suite 1506, Chicago, IL 60611, or call Medical Director, (312) 944-6969. Please don't delay in responding to this wonderful opportunity as there are only four positions available.

INTERNIST WITH SUB-SPECIALTY in rheumatology to join well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, IL 60178.

FAMILY PRACTITIONER—BC/BE wanted to join busy practice in highly desirable Chicago suburb (Geneva). Send C.V. to: Dr. John Kelly, 13 S. Second St, Geneva, IL 60134. (312) 232-0319.

FAMILY PRACTITIONER/WI: BC/BE to join 23 physician multispecialty group. Progressive hospital equipped with CT scanner. Service population of 60,000/80,000. University community. Reply: Administrator, 2501 Main St., Stevens Point, WI 54481; or call collect (715) 344-4120.

ALLERGY ASSOCIATE—(ABAI BE/BC) to join long successful allergist within 60-physician group (FFS, HMO, PPO) in growing, affluent Chicago suburb. Excellent starting salary/full benefits leading to partnership. Send C.V./availability: Box #2040, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CORRECTIONAL HEALTH SERVICES is seeking board-eligible or board-certified family practitioners and internists for full and part-time positions in Illinois Department of Corrections facilities. For more information

send C.V. to Stanley Harper, M.D., Correctional Health Services, 467 W. Deming, Suite 704, Chicago, IL 60614; (312) 883-8705.

PHYSICIAN OPPORTUNITIES: Current openings full or part time in family practice/internal medicine—solo, group or clinic based positions affiliated with fully accredited teaching hospital in Chicago. Varying financial opportunities—excellent benefits. Forward C.V. to Box #2039, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GENERAL INTERNIST. Marshfield Clinic, one of the nation's largest multispecialty private groups, is seeking several board certified/board eligible general internal medicine specialists to join its expanding 18 member section. Internal medicine residency program, university affiliation, research foundation, and large regional referral base contributes to a very stimulating environment. Unique big city medicine opportunity in a family oriented rural setting. Please send curriculum vitae to: John P. Folz, Director, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449, or call collect at (715) 387-5181.

ORTHOPAEDIC SURGEON— Join large Illinois manufacturing company as a full-time employee orthopaedic consultant. Some office orthopaedics, benefits consultation, cost containment, workers compensation evaluations, etc. Candidate must be board certified, licensed in Illinois, have recent private practice experience, very good written and oral communication skills, and a self starter. Salary is competitive plus liberal company fringe benefits including malpractice and relocation expenses. Send full curriculum vitae to Box #2041 c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GREEN BAY, WISCONSIN—27 physician multi-specialty group seeking BC/BE physicians in the following specialties: family practice, ophthalmology, ENT, dermatology, plastic surgery, radiology, OB-GYN, internal medicine and pediatrics. Green Bay is a progressive community with an easy lifestyle, ample outdoor activities, excellent schools and cultural activities. The clinic offers competitive salary and excellent fringe benefits. Interested physicians please contact: W. J. Mommaerts, Administrator, West Side Clinic, s.c., Post Office Box 19070, Green Bay, WI 54307-9070.

EMERGENCY MEDICINE For emergency physician who possesses excellent clinical and trauma skills within a group of seven emergency room physicians—located in a beautiful northwest Wisconsin area. Position opening July, 1987. Please send C.V. to: Dr. M. Jaghlit, 900 W. Clairemont Ave., Eau Claire, WI 54701; or call (715) 839-4404.

PROGRESSIVE DOCTOR needed for position in a rapidly expanding holistic health center located in the state capital. Low over-head, no start-up costs, established patient load. Send resume to: Dr. Kevin W. Imhoff, 2626 South 5th Street, Springfield, IL 62703.

UNOPPOSED PRACTICE OPPORTUNITY for rheumatologist, board eligible or board certified to associate with American Board of Internal Medicine internist in expanding medical practice, competitive salary guaranteed with incentive formula, full partnership at the end of one calendar year. Two 400 bed hospitals in city of 100,000, drawing area 150,000. Central Illinois. No other rheumatologist in town. Excellent opportunity. Send C.V. and inquiries to Box #2045, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FAMILY MEDICINE—Several outstanding family practice opportunities available in an attractive city of 80,000 people along the Mississippi River. Competitive salary and benefits with paid interview and relocation expenses. Call Robert A. Douglas, M.D. 1-800-327-1585.

FAMILY PRACTITIONER. Marshfield Clinic-Colby Center is seeking a board certified/board eligible family practitioner to join another family practitioner in an established office based group practice in Colby, Wisconsin. The Colby Center offers the family practitioner the autonomy of a private, primary care practice, plus the financial and professional resources of Marshfield Clinic, a 250 physician multispecialty group. This physician would enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Excellent salary and benefits. Please send curriculum vitae to Robert Peterson, Director, Regional Services, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449, or call collect at (715) 387-5498.

WOMEN'S ORIENTED MEDICAL Clinic looking for family practitioner or internist—room to grow. 45 miles west of Chicago. Reply to Women's Health Center, 1240 North Highland Avenue, Suite 17, Aurora, IL 60506.

PRIVATE PRACTICE OPPORTUNITIES: Family practice, internal medicine, no cash outlay, attractive salary, excellent incentive compensation, liberal benefits including malpractice. Prospective: OB/GYN, pediatrics, psychiatry. Send C.V. to Don Hoit, Farris & Associates, Inc. 16216 Baxter Road, Suite 200, Chesterfield, MO 63017; (314) 532-4880.

SOUTHWEST: Thomas-Davis Medical Centers, a multi-specialty group practice network in Tucson, Tempe, and Green Valley, Arizona, needs an allergist and a dermatologist for its Tempe facility (located in the Phoenix area). First year guarantee plus incentive. Early shareholder in both medical practice corporation and HMO. Excellent fringe benefits and profit sharing retirement. Fee-for-service, as well as doctor owned HMO. Must be board eligible or certified. Call or write: James J. Vitali, Executive Administrator, P.O. Box 12650, Tucson, AZ 85732.

INTERNAL MEDICINE—Kenosha, Wisconsin. Join 5-physician IM group. All members certified. Growing practice. Affiliated with two major hospitals—565 beds. Competitive salary and benefits. City of 76,000—50 miles north of Chicago on Lake Michigan. Phil Kelbe, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, (414) 785-6500.

TWENTY-NINE PHYSICIAN multispecialty clinic located in desirable east central Wisconsin location is seeking board certified or board qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested, contact D. F. Sweet, M.D., Fond du Lac Clinic, S.C., 80 Sheboygan Street, Fond du Lac, Wisconsin 54935.

OBSTETRICIAN/GYNECOLOGIST—Young, ten-physician, multispecialty group near St. Louis, seeks second OB/GYN. Virtually all deliveries are at a 220-bed hospital with a 25-bassinet Level II nursery. The group moved into a new 9,000 square foot, well equipped clinic building in 1985. For detailed information, send your C.V. or call: Jim Huber, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; (414) 785-6500 (collect).

ORTHOPEDIC SURGEON, emergency medicine, family practice, OB/GYN, general internist & ENT—needed for two-hospital, historic river town of 20,000. Drawing area of approximately 60,000 with new 19,000 acre recreational lake. Unlimited potential. Contact: Carol Neil, Physician Recruitment, 623 Broadway, Hannibal, MO 63401; or call (314) 221-3107.

MAJOR MEDICAL CENTER/Chicago Area. Practice opportunity in newly opened medical office building and other sites in the western suburbs. We wish to make arrangements to establish practices in internal medicine and OB/GYN. This represents an opportunity for physicians interested in a long-term, stable environment. Potential practice enhancements offered include compensation guarantees, free rent during start-up phase, and other practice inducements. Contact Mr. H. Cloys at (312) 951-7992.

TWO FAMILY PHYSICIANS needed to establish branch clinic in southern Illinois. Area is medically underserved by physicians and the main clinic wishes to offer an expansion of services. New physicians would be members of main clinic, a 30-physician multi-specialty group. Clinic is principal referral center for all of southern Illinois. Hospital, located in branch clinic community, is fully accredited, 117-bed acute care facility. Clinic will either construct new facility or renovate and occupy existing clinic space. Interest in obstetrics preferred. For more information contact: Fox Hill Associates, One Greentree Centre, Suite 201, Marlton, NJ 08053, or telephone (609) 596-0661.

CHICAGO ILLINOIS: CHAIRMAN of department of radiology. Unique opportunity to direct dept. of radiology in a progressive community hospital with 325 beds. 80 physicians officed at the hospital. Should be board certified with five years experience and demonstrated skills in diagnosis, angiography, and fluoro, V/S, CT, mammography, and

intervention. Cancer Therapy Center opens 8/4/87 for a population of 1.5 billion. Salaried position with bonus, incentives, and liberal fringe benefits. Send C.V. to: John L. Burke, Associate Administrator, Jackson Park Hospital, 7531 Stony Island, Chicago, IL 60649. (312) 947-7779. EOE M/F.

INTERNAL MEDICINE—Peoria, Illinois. Several practice openings available in group and private practice settings. Affiliated with 500-bed hospital. Financial incentives provided. City of 125,000 on Illinois River. Phil Kelbe, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; (414) 785-6500.

LOCUM TENENS, OPHTHALMOLOGY: Illinois licensure and insurance required. Reply to Box #2050, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Deborah Bergun, Staffing Specialist. National Emergency Services, Inc. 255 Executive Drive, Suite 104, Plainview, NY 11803; or call (800) 645-4848, or (516) 349-0100.

OTOLARYNGOLOGY—Canton, Illinois, 30 miles SW of Peoria. Join 11-physician multispecialty group. Affiliation with 225-bed hospital and trauma center. Diverse practice-referral base exceeds 50,000. Excellent salary and benefits. Phil Kelbe, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; (414) 785-6500.

GEORGIA, DIRECTOR: Low volume emergency department in pleasant, smaller community. Located 1½ hours from Georgia's Golden Isles. Competitive compensation, benefit package, no on-call responsibilities. Professional liability insurance procured on your behalf. For more information contact: Sheila Murphy, Coastal Emergency Services, Inc., P.O. Box 925, Augusta, GA 30903; collect (404) 724-3368.

FAMILY/INTERNAL MEDICINE practice available immediately for sale, contract or partnership in Monmouth, Illinois—population 15,000. Well established, fully equipped. Excellent, friendly family community. Terms negotiable. Reply to Box #2031, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS—SEEKING PHYSICIANS for hospital based industrial medicine clinics. Directorship and assistant directorship available. Attractive compensation and malpractice insurance provided. Contact Emergency Consultants, Inc., 2240 S. Airport Road, Room 17, Traverse City, Michigan; (800) 253-1795, or in Michigan (800) 632-3496.

FACULTY—AMBULATORY PEDIATRICS—the department of pediatrics, University of Illinois College of Medicine at Peoria, has a full-time faculty position available March 1, 1987, or after. Teaching, service and research responsibilities. Board certified/eligible in pediatrics. Training in adolescent medicine desirable. Preference given to active clinical practice brought into University program. Rank and salary commensurate with qualifications and responsibility. The University of Illinois is an affirmative action-equal opportunity employer. Send curriculum vitae and three reference letters to: William H. Albers, M.D., Professor and Chair, Department of Pediatrics, University of Illinois College of Medicine at Peoria, Box 1649, Peoria, IL 61656. Phone: (309) 655-2570.

EMERGENCY MEDICINE—Level I Trauma Center. Major university teaching hospital is conducting a search for emergency department physicians. Excellent remuneration and challenging medical environment. Interested applicants should send resume to: Barry R. Trautman, HealthLine Physicians Services, 8401 Hanley Industrial Court, St. Louis, MO 63144.

CARDIOLOGIST, B/E, B/C: Looking for associate in the established practice of cardiology. Excellent opportunity; modern progressive hospital in an ideal southern family community. Reply to Box #2053, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS (Chicago, west & central areas): Seeking emergency medicine physicians for full time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; (800) 253-1795; or in Michigan (800) 632-3496.

SITUATIONS WANTED

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy, (312) 337-4221.

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box #2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS LICENSED MD, experience in GP, pediatrics, adolescent, and addiction. Looking for position in state, municipal or university centers, clinics, hospitals. Please call anytime (312) 652-9770.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED RADIOLOGIST, university trained, 10 years in practice, available for part time coverage of office, clinic, etc. after July 1 in Chicago area. Reply to Box #2049, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD ELIGIBLE, university trained young pediatric cardiologist seeking position in private practice setting with hospital affiliation, or hospital base practice. Reply to Box #2052, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DIAGNOSTIC RADIOLOGIST: Board certified, interventional and imaging fellowships, experienced in all modalities, seeks locums short term. Available most weekends, some weeks including weekdays. Reply to Box #2051, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE, LEASE OR RENT

FOR RENT: Beautiful and well furnished office for rent for any specialty in growing area of Carol Stream, IL. Call (312) 830-3000 after 5:00 p.m.

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

X-RAY MACHINE Universal 300 MA 125 KVP. Stationary table. Upright chest unit. Illinois State nuclear safety approved. New tube. Works perfectly. Ms. Moore, Treister Orthopaedics. (312) 633-5866.

SELLING FAMILY PRACTICE Southside. Grossing $125,000. Working 3 hours. More potential if fulltime devoted. Selling cheap with equipment. Relocating. Excellent office. (312) 333-6789 evenings/weekends.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)244-3355, (312)662-1664.

FOR SALE: Two year old Vitalograph Spirometry Model R and accessories in excellent condition. $400.00 or best offer. Hewlet-Packard EKG Model 1500 A in perfect working condition with accessories (mount, paper, cutter) $350.00, or best offer. A. Sosenko, M.D., Joliet, IL; phone: (815) 725-2653.

PHYSICIANS SUITE Available. Specialist needed—prefer dermatologist. In Elsdon Medical Pharmacy; 4258 W 55th Street, Chicago, Ill 60632. Contact; John Wadas (312) 582-2660.

DES PLAINES. Medical suite in beautiful Lee Street atrium building. Waiting room, reception, offices, two exam rooms. Newly carpeted. Competitive rental plus attractive move-in bonus. Shaker. (312) 524-0800.

WELL-ESTABLISHED PEDIATRIC practice for sale. Located central Illinois. Medium size community. Will introduce up to one month. Grossing over $200,000. Reply to Box #2046, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE: Well-established general practice grossing approximately $175,000. Cahokia, IL—close to St. Louis, MO. Fully equipped medical clinic (approx. 2,800 sq. ft.) also available. Spacious waiting area, 7 exam rooms, large parking lot, clerical office with vault, private doctor's office, lab, x-ray. Call Magna Trust Company (618) 233-2120, ext. 22.

FAMILY PRACTICE Grossing $150M and office building in $3mil, 5 acre professional complex for sale. 1800 square feet, fully equipped, 5 exam rooms, beautifully landscaped. Located in Modesto with easy access to San Francisco. Available now. Contact: Emile Lengyel, M.D., 4141 Carver, Modesto, CA 95356; (209) 522-2544.

MORTON GROVE, Dempster and Austin. Just west of Edens Expressway. 3 examining and 3 other rooms, walk in closet and reception room. Elevator building. Move in condition. We will work closely with the right party. Call (312) 564-4050.

CHICAGO: SPACE for medical office, lab, group or building. Up to 120,000 square feet at $10/sq. ft. 24 hour security. Sheridan/4700 North. Call (312) 743-2043.

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Worth the Effort



This is the twelfth and final President's Page of my tenure as ISMS spokesman. During the past year, I have tried to address topics of concern that were timely as well as important.

Some positive things happened in the legislative area. Four of the five challenged portions of our 1985 legislative malpractice reforms were found to be constitutional by the Illinois Supreme Court. Recommendations were received from the Governor's Task Force on Medical Discipline. Although blocked by the General Assembly in 1986, they will be acted on this year as part of the Medical Practice Act rewrite. The Medical Disciplinary Board continues to become more active, even without implementation of the task force recommendations.

We are tackling the problem of the impaired physician by publicizing the information on impaired physician panels through hospital medical staffs and *IMJ*. Intervention teams are in place throughout Illinois. Through these activities, we have identified and helped more physicians. This should remain a primary objective of ISMS.

We have continued trying to make our members aware of the changing modes of health care delivery—how they affect us and our patients. Many physicians have availed themselves of our alternative health care contract review service to become better informed on what these contracts really mean. I have tried to stress that we, as persons licensed to practice medicine, should be the ones who make sure quality of care is not compromised by the method of health care delivery.

Finally, we are in the midst of launching some extremely important legislative proposals. We are in close contact with the Department of Registration and Education, which is responsible for rewriting the Medical Practice Act before it goes to the General Assembly. We have gone over the Act carefully, have sought input from our membership, and have offered recommendations for the rewrite. I promise we will be very active in the House and Senate when the debating and voting occur.

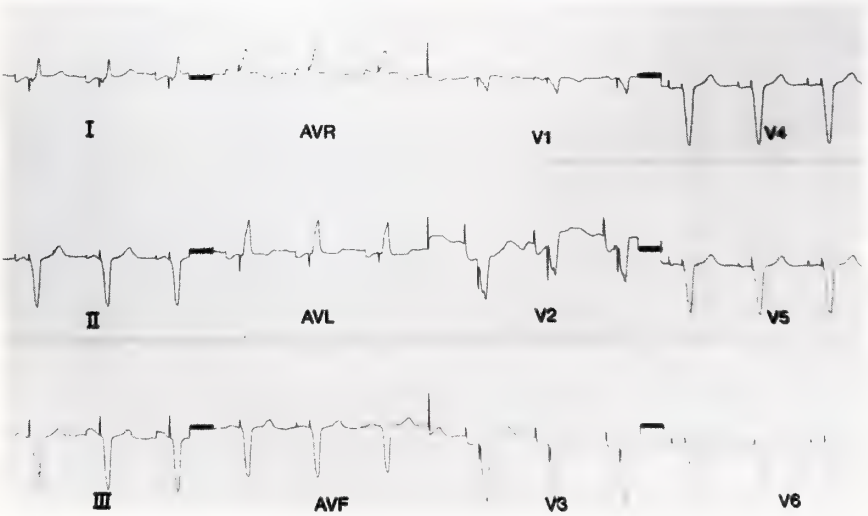
The membership and all citizens of the state should be aware by now that ISMS is introducing two more pieces of legislation to improve the medical malpractice climate in Illinois: a cap of $250,000 on noneconomic awards and a shortened statute of limitations for minors injured because of medical negligence. My concern is that ISMS physician members will not be as active this year as we were two years ago in selling our case to the legislature, the media and the public. Action teams have again been formed, but, in many instances, are not yet meeting or launching letter writing campaigns to legislators and the media. Perhaps there has been the misconception that the 1985 Springfield rally caused most of our legislative success. The rally was only the culmination of months of multiple meetings with legislators and others with political influence. A rally is meaningless without the massive education and persuasion activities preceding it.

It has been an honor and a pleasure to serve ISMS as President. The President's Tour, which 12 months ago seemed an impossible task, has been an experience well worth the effort. I have enjoyed meeting many colleagues and I am heartened by the fact that many individuals are becoming more interested in the affairs of the Society. This bodes well for the future of organized medicine. ◂

Jere E. Freidheim, M.D.
President

EKG OF THE MONTH

CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This patient was a seventy-two-year-old woman who complained of near syncope. She said the spells of marked weakness and near fainting would come on suddenly, regardless of her activity. They could be relieved by lying down or helped by lowering her head. She denied ever losing consciousness. Her past medical history included a nodular goiter without symptoms of hypothyroidism or hyperthyroidism fifteen years ago. Blood pressure was 150/84mmHg. Thyroid enlargement was evident. Pulse was irregular at a rate of 80 beats per minute with some long pauses. A twelve lead ECG was abnormal with complete right bundle branch block, left anterior hemiblock, and a prolonged PR interval. A chest X-ray was normal. Continuous electrocardiographic monitoring over twenty-four hours showed periods of 2:1 atrioventricular (AV) block as well as higher grades of AV block. These longer periods of AV block were associated with the symptoms of weakness and near syncope. A permanent pacemaker was surgically placed without difficulty. Three days later, this ECG was obtained.

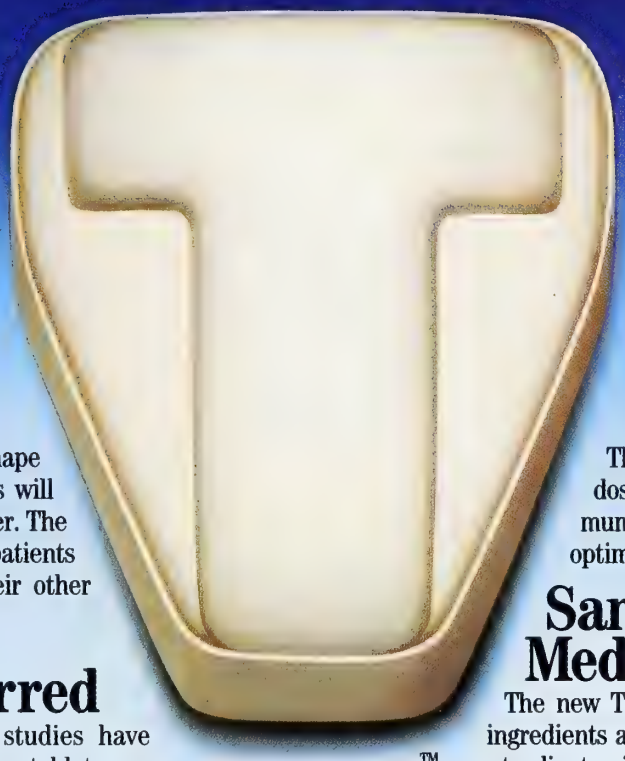
Questions:

1. **This twelve lead ECG shows:**
   - A. Complete right bundle branch block and left anterior hemiblock.
   - B. New onset complete left bundle branch block.
   - C. Accelerated idioventricular rhythm.
   - D. Well-functioning AV sequential pacemaker.
   - E. Malfunctioning AV sequential pacemaker.

2. **Treatment for this patient could include:**
   - A. Pacemaker lead repositioning.
   - B. Activation of the pacemaker circuitry with a magnet.
   - C. Continuous electrocardiographic monitoring.
   - D. Intravenous lidocaine.
   - E. None of the above, or no treatment.

(Continued on page 195)

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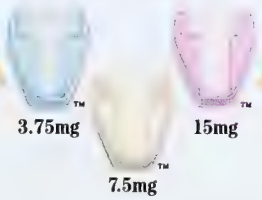
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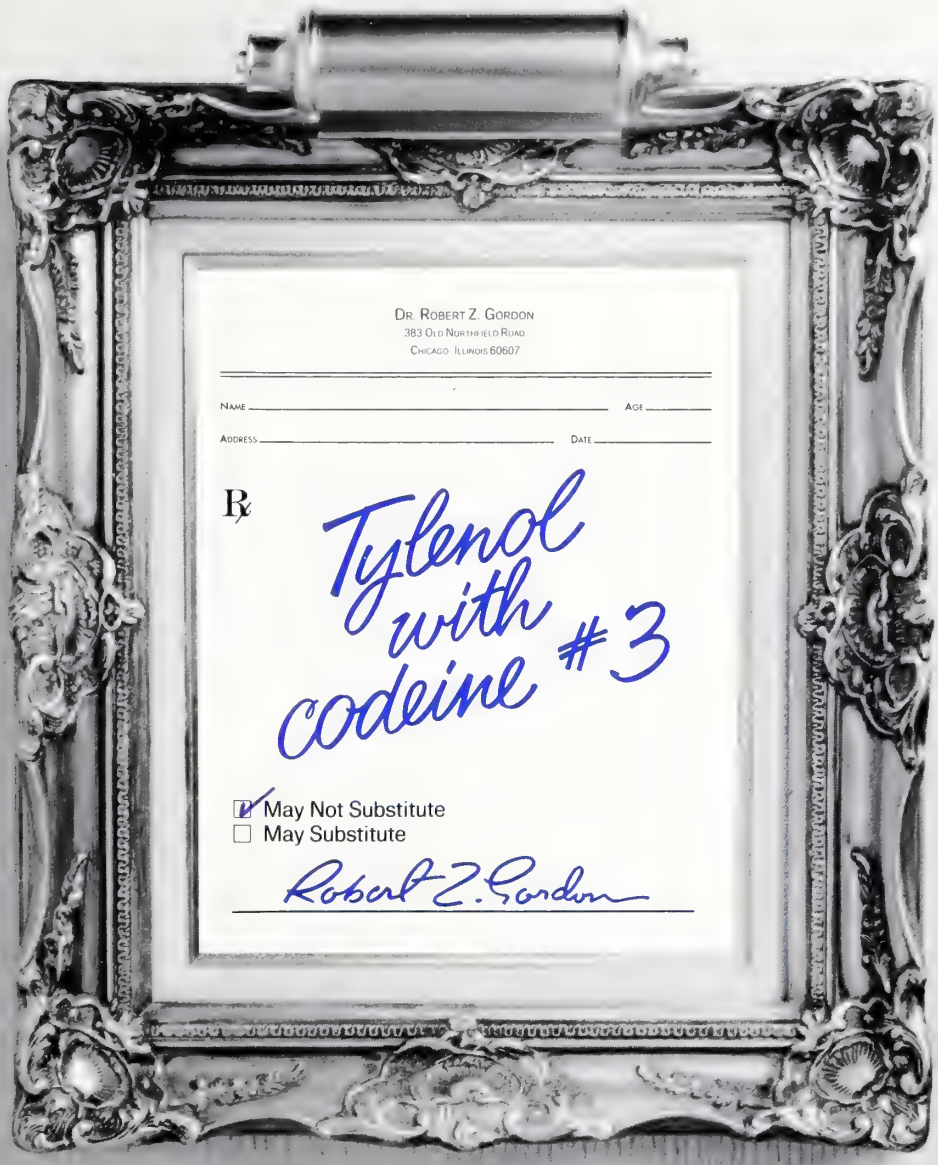
Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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Guest Editorial

Le(s)t Reason Prevail

By Richard J. Sassetti, M.D./Chicago

There has been increasing interest in responding to public concern about AIDS by developing designated blood donor programs for both individuals and groups. Legislation requiring them has been introduced.

These proposals are based upon the assumptions that designated donors are safer than the average donors and can be recruited without additional costs. Closer examination suggests that it may not be true; in fact, the opposite may be closer to the fact.

Because of their relationship to the recipient, designated donors are generally responding to some element of coercion. We are reminded every day that AIDS, hepatitis and the high risk behavior associated with them are found in every stratum of the socioeconomic scale and across every demographic division. It is extremely unlikely that a patient's close friends or relatives will exclude themselves on the basis of their high risk activity. We are all aware of the social opprobrium associated with admission of high risk activity. The circumstances surrounding directed donations prompt behavior which nullifies the known benefits of the well publicized self-exclusion program. It may bring unsafe donors who otherwise would have stayed away.

It has been argued that designated donors will be a source of additional blood, free of recruitment costs. A current proposal requires that blood designated for a patient be held 20 days for that patient. Experience shows that much of this blood will be sequestered for its entire shelf life because doctors are afraid to give up the resource. If released, because of its short shelf life, 25% to 30% of it will be wasted.

The concept of setting blood aside for a particular group is contrary to all humane and ethical considerations. It is difficult to articulate a more cogent argument, and impossible to view as a constructive step. The position taken regarding organ transplantation strongly opposes any deference to groups for whatever reason. The same concerns that apply to organ donations should apply to blood donations.

It is the opinion of the major blood banking organizations that widespread use of designated donations will reduce the number of regular donations to perilously low levels. "Group" donations will worsen this and costs associated with efforts to compensate will be sizeable. In this era of increasingly restricted reimbursement fees, the cost of designated donations must be considered.

A common counter-argument proposes that, since this is a special procedure, its cost be passed on to the user. While this may be true for community blood centers, it is another matter for hospitals. There, the cost can not be passed on to patients under Medicare or Medicaid, and these patients represent about 50% of cases in Illinois hospitals. To effectively recover the cost, it must be passed on to third party payors, who will soon recognize that they are paying for an incremental service with no therapeutic advantage. As a result, cost recovery will be difficult.

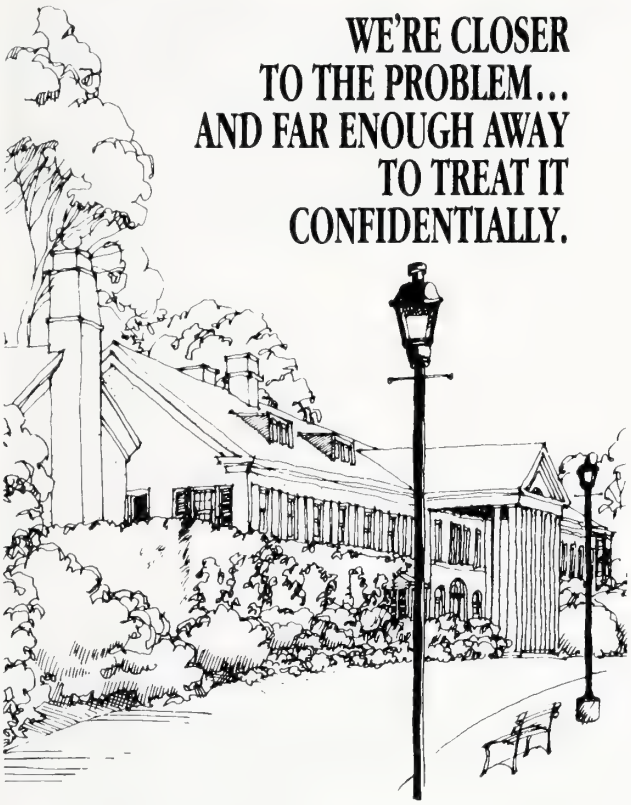
Nothing currently prohibits designated donations. If the supporting arguments were valid and the benefits clear, the blood banking community would have responded energetically without a mandate.

But, since there is no benefit and the costs and risks are great, the only remaining reason is to assuage public discomfort. To accommodate emotional reasons is not in the best interest of the people of Illinois, and will only validate unfounded assumptions.

Finally, lest history repeat itself, recall that before blood banking, designated donations were the only source of blood. The ensuing multitude of problems stimulated the development of blood banking and accounts for the ready acceptance of banked blood as a substitute. Many of the therapeutic measures we daily employ are based on the ready availability of an adequate, maximally-flexible supply of blood. Designated donors may seriously alter this. To mandate, for reasons of questionable merit, a major alteration in a system which works well, is a potentially dangerous step. ◀

Richard J. Sassetti, M.D., Chicago, is a hematologist specializing in hematologic oncology and immunohematology affiliated with Rush-Presbyterian-St. Luke's Hospital as director of the blood center and acting director of the office of consolidated laboratory services. A professor of medicine at Rush Medical College, Dr. Sassetti is chairman of the medical committee of the blood services board of the American Red Cross and serves as physician liaison to the Illinois Department of Public Health's clinical laboratory and blood bank advisory board. He is a member of the ISMS task force on AIDS, a past president of the Illinois Association of Blood Banks, a past chairman of the IDPH blood banking committee and a past member of the American Red Cross board of directors.

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Reading Between the Lines

Today's alternative delivery systems are not built of brick and mortar, steel or glass, but rather of paper. The systems are constructed by contracts. For example, the structure of HMO, Inc., may be set up by four basic contracts: a hospital contract with reimbursement on a per diem, per case basis; a primary care physician contract which compensates the physician on a capitated basis (a fixed amount per member, per month for each enrollee who chooses the physician, regardless of utilization); a specialist physician contract with compensation on a modified fee-for-service basis; and contracts with ancillary providers (*e.g.*, ambulance, home health).

This, of course, is only one basic model. Perhaps a physician organization, such as an IPA, has formed a joint venture with a hospital. In this structure, the joint venture may have a contract with, and also an ownership interest in, HMO, Inc. There is an agreement between the IPA and the joint venture, and also, contracts between the IPA and its physician members. In addition to the hospital, the joint venture may have contracts with an administrator, a medical director, and ancillary and home health providers. The contractual configuration of alternative delivery systems seems endless. But one element remains constant: the Physician Participation Agreement. It is the core of the system because it is the physician alone who is licensed to practice medicine.

To evaluate a contract properly, the informed physician knows how to read between the lines. Sometimes, what the contract does not state, define or explain is as important as what is stated. This is frequently illustrated by the utilization review provisions. Utilization review is a crucial component in all alternative delivery systems because it is one way to contain costs. It is also critical for the physician because the review policies, rules and procedures may curtail the physician's exercise of independent medical judgment, and may adversely affect the quality of care. Consider this provision:

> Physician must cooperate with, participate in and be bound by the decisions of the HMO, Inc.'s utilization review, peer review, credentialing and grievance programs, policies, rules and procedures as they exist and may be changed or adopted from time to time.

Obligations stated in this fashion immediately trigger several questions, the answers to which are not contained in the contract.

What does the requirement stating that the physician "cooperate" with HMO, Inc.'s programs, policies, rules and regulations entail? What are the consequences of noncooperation? Do physician providers have any input into the development and adoption of the policies, rules and procedures? If not, who develops them and what are their qualifications? What assurances exist that quality of care is protected under the programs? According to this provision, HMO, Inc. may be able to unilaterally change the programs, policies, rules and procedures without advance notice to, or consent of, the physician. Is there a prompt, fair, and neutral appeals procedure to resolve disputes, enabling physicians to contest arbitrary policies, rules and regulations?

Does the physician's required participation in the review programs include participation on review committees? Unlike participation on peer and utilization review committees in the hospital setting, participation on peer and utilization review, quality assurance, grievance or credentialing committees, or service as a medical director in the alternative delivery system setting is not covered by the Illinois State Medical Inter-Insurance Exchange policy. Most likely, it is not covered under other profes-

sional liability insurance policies either. The Illinois State Medical Inter-Insurance Exchange policy only provides insurance coverage in cases involving *medical malpractice,* and does not cover liability allegedly resulting from any type of *administrative negligence* as a result of participation on these committees. Prudence dictates that the physician determine whether HMO, Inc. provides the insurance coverage to protect physicians from liabilities and claims resulting from committee participation.

What exactly *are* the programs policies, rules and procedures? The informed physician obtains, carefully examines and fully understands them in order to evaluate the contract. Oral promises or explanations by HMO, Inc.'s representative are inadequate because terms which are not made a part of the written contract are generally not binding upon the parties. The physician *would* be obligated to "participate in, cooperate with, and be bound by policies, procedures, rules and regulations" because that is part of the written contract. Oral answers to the questions raised *would not* be binding unless they were written into the contract. Reading between the lines can usually be avoided when the contract contains the actual review policies, procedures and rules in an exhibit or attachment to the contract. If the contract specifically states that the exhibits are a part of the contract, then the review mechanisms can only be changed according to the provisions for amending the contract, which *may* require the written consent of both parties.

A contract between an IPA and its physician members sometimes triggers similar questions, the answers to which are not contained in the contract or the IPA bylaws. Suppose the IPA/physician contract requires committee participation as defined in the bylaws, and the bylaws require peer, utilization and credentialing committee participation. According to the bylaws, the IPA will indemnify the physician for committee activities. Generally speaking, this means the IPA will defend the physician and assume the liability of the physician for committee activities. In this situation the question left unanswered is whether the IPA has insurance to fund its promise. If not, the physician's reliance on the indemnity may be misplaced because many IPA corporations do not have the corporate assets to fund the indemnification.

Because you're an informed physician who recognizes the complexity of these contracts, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you objective comments on any HMO, PPO or IPA contract at no cost. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA, you may not band together with other physicians to negotiate the contract collectively because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself, or with your personal attorney or financial advisor. ◂

ISMS Physician Help Line

Are you troubled by chemical dependency, alcoholism, physical or mental problems, or concerned about someone who has an impairment? Are you having problems dealing with your involvement in a malpractice suit?

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The Physician Help Line is open 24 hours, 7 days a week. Calls will be answered as soon as possible, and information is shared only with the physicians helping the person who calls.

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by William M. Greenlee, M.D., Department of Radiology, Loyola University Medical Center, Maywood.

Patient One has a three-day history of nausea and vomiting. Patient Two has a small bowel obstruction with crampy abdominal pain. Both patients have the same diagnosis.

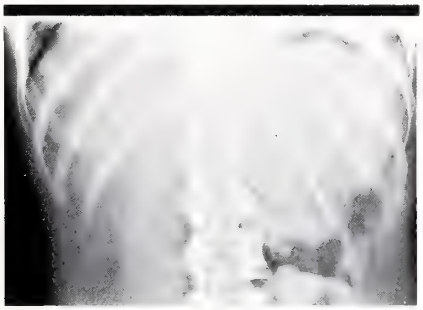


Figure 1
Patient One. Supine view of the abdomen. There are surgical clips in the epigastric region from previous partial gastric resection. There is a mottled bubbly appearance in the left upper quadrant of the abdomen.



Figure 2A
Patient Two. Barium enema. There are surgical clips in the epigastric region from previous gastric surgery. The patient has a small bowel obstruction (note gas-filled dilated loops of small bowel). The barium-filled colon is normal.

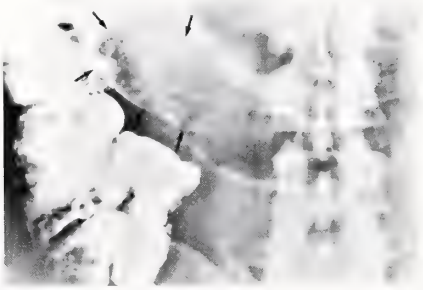


Figure 2B
Patient Two. Reflux of barium through the ileocecal valve outlines an intraluminal filling defect in the distal ileum (arrows).

Your diagnosis?

1. Abscess
2. Intraluminal blood
3. Intussusception
4. Bezoar
5. Carcinoma

(Continued on page 193)

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ABSTRACTS OF ACTIONS

January 17, 1987 *ISMS Conference Complex*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

1988 BUDGET

The Board of Trustees reviewed a projection for 1988 which results in a deficit in unrestricted fund balance of $222,000 in the operating fund at December 31, 1988. The Board continues its ongoing effort to maintain dues at the current level. Accordingly, to maintain dues at the current level and eliminate the projected deficit in fund balance, the Board took the following action: (A) Incorporate "Action Report" and "On the Legislative Scene" in the *Illinois Medical Journal* in 1988 (at a projected budgetary savings of $93,800); (B) Utilize an estimated $125,000 to $150,000 of interest and dividend earnings in the Permanent Reserve Fund for the 1988 operating budget; and (C) Require that any program expansion or new program proposed to the Board of Trustees requesting additional funding must be accompanied by a fiscal note including information as to the specific cost and the amount of any proportional dues increase.

REVISION IN ILLINOIS CLINICAL LABORATORY ACT

The IDPH Clinical Laboratory and Blood Banking Advisory Board has developed proposed legislation to revise the Illinois Clinical Laboratory Act to create a multi-tiered system of regulation. This new approach to regulation stems from the increasing number of lab services and tests performed in physicians' offices, hospital-owned ambulatory care centers, immediate care centers, ambulatory surgical treatment centers and HMOs.

The Board agreed to support the development of a multi-tiered system of lab regulation that provides for an exemption for physicians who perform a small number of minor laboratory tests in their offices.

CLOSING A MEDICAL PRACTICE

The Board authorized creation of a pamphlet for distribution to Society members, which presents, in a concise and clear fashion, the actions which need to take place following a physician's death. This document urges physician families to plan ahead of such a situation and provides suggestions for dealing with the deceased physician's patients, medical records, medications, licenses, corporation, and malpractice insurance, as appropriate.

IDPH DPT IMMUNIZATION POLICY

The Board adopted a position supporting a recent IDPH statement on DPT vaccinations. IDPH has stated it will continue to support the use of DPT as the vaccine of choice for use in infants and children through age six; and DT (pediatric type) vaccine is to be used for only bonafide instances of contraindication found after a thorough evaluation, which considers the risk to a pertussis-susceptible child compared with the risk of possible reactions; and where DT is indicated, a physician's statement of a medical contraindication is necessary to fulfill school immunization requirements.

COMMITTEE ON DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Nitrogard (Nitroglycerin Transmucosal); Roxicet (Acetaminophen, Oxycodone HCL); Aerobid (Flunisolide); Tenex (Guanfacine); Calan SR (Verapamil HCL); Pepcid (Famotidine).

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Calcibind (Cellulose Sodium Phosphate); Urocit-K (Potassium Citrate); Peridex (Chlorhexidine Gluconate); Marinol (Dronabinol); Tegison (Etretinate); Pramosone (Hydrocorti-sone Acetate, Pramoxine HCL); Cordarone (Amiodarone).

OTHER ACTIONS

In addressing various other issues, the Board:

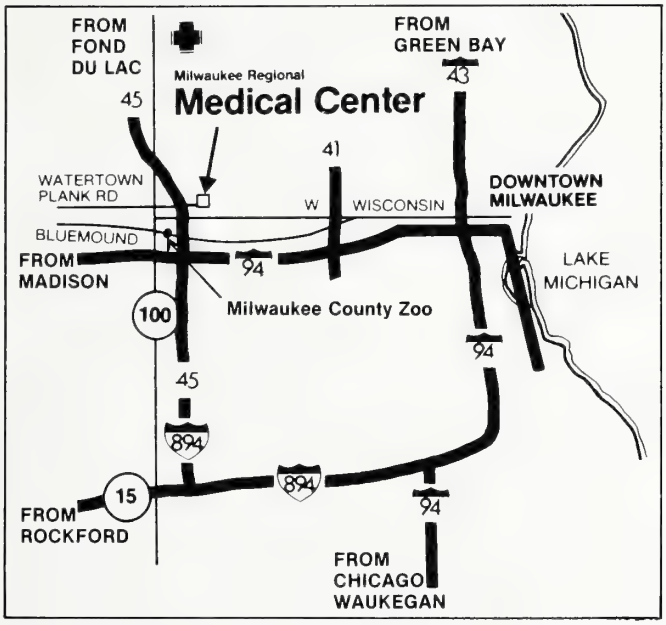
- Filed the Financial Statements for the period ended September 30, 1986; January 6, 1987, IMPAC Collection Data; January 7, 1987, Dues Payment Report; and Requests for Changes in Membership Status.
- Modified previous action and ratified an expenditure not to exceed $100,000 for remodeling and refurbishing the ISMS Springfield Headquarters.
- Reviewed the tentative schedule for the All-Member Conference and approved holding the All-Member Conference at the Hyatt Oak Brook Hotel, November 7-8, 1987.
- Approved a proposal that during the Annual Meeting a program on the Medical Practice Act be conducted on Saturday afternoon, April 11.

(Continued on page 186)

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Action Team Update

After spending the months of November and December organizing for the medical profession's latest Professional Liability Initiative, physician action teams have begun in earnest the process of contacting legislators to discuss further malpractice reforms. Action teams have been the mechanism advocated by the Illinois State Medical Society to implement the Society's drive for a cap on noneconomic damages in malpractice cases and a reasonable statute of limitations for suits involving minors.

A host of meetings were held between physicians and legislators during the months of January and February. Some 20 action team representatives from hospitals in Mendota, Dixon, and Rochelle met with **Sen. Harlan Rigney** (R-Freeport) and **Rep. Myron Olson** (R-Dixon) on January 8. Both legislators agreed there is a need for further reform. Action team leaders at the three hospitals are **Drs. Stephen Schubert, Don Edwards,** and **Don Hinderliter.**

The St. Clair County Medical Society's legislative committee, headed by **Dr. Robert Wanless,** met with **Rep. Monroe Flinn** (D-Granite City) on January 6. Refusing to make a commitment of support for the medical community's proposals, Rep. Flinn indicated he wanted to study the issue further. On January 22, the committee met with **Rep. Ron Stephens** (R-Caseyville) and held a productive discussion on further reform needs.

ISMS President **Dr. Jere E. Freidheim** discussed the legislative initiative at a January 29 meeting of the North Suburban Branch of the Chicago Medical Society. Legislators in attendance were: **Senators Arthur Berman** (D-Chicago) and **Howard Carroll** (D-Chicago); and **Representatives Margaret Parcells** (R-Glenview), **Grace Mary Stern** (D-Highland Park), and **Woods Bowman** (D-Chicago). Lively exchanges between the legislators and CMS branch members took place before, during, and after the meeting.

Earlier that day, Rep. Stern was a featured guest at a breakfast meeting with the **Highland Park Hospital** action team headed by ISMS District 1 Trustee **Dr. David B. Littman.** Later, approximately 20 representatives from **Princeton, Spring Valley,** and **Kewanee Hospitals** met with **Rep. Richard Mautino** (D-Spring Valley). Rep. Mautino agreed to support both ISMS proposals. Action team leaders instrumental in organizing the session with Rep. Mautino were ISMS President-Elect **Dr. Allan Goslin,** and **Drs. K. Dexter Nelson, Don Gallagher,** and **William Ebert.**

Representative Ron Wait (R-Belvidere) attended a Feb. 2 meeting of the Boone County Medical Society, chaired by the society's president, **Dr. Allen Sherman.** Also attending the meeting was ISMS District 12 Trustee **Dr. Raymond E. Hoffmann.**

On February 5, **Senator Virginia MacDonald** (R-Mount Prospect), attended a morning meeting with physicians at **Northwest Community Hospital** in Arlington Heights. Led by **Dr. Alfred J. Clementi,** immediate past chairman of the ISMS Board of Trustees, the physicians attempted to impress upon Sen. MacDonald the need for the latest legislative proposals.



Attending the January 28th meeting of the North Suburban Branch of the Chicago Medical Society were (left to right): John W. Weiss, M.D. (North Suburban Branch President); Representative Woods Bowman (D-Chicago); Senator Howard Carroll (D-Chicago); Jere E. Freidheim, M.D., (ISMS President).



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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2, 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Revised, April 1982. 5685

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IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 171, No. 3
March 1987

Diagnosis and Treatment

Hypocalcemia Following Total Thyroidectomy

By Joseph R. Durham, M.D., Frank A. Baciewicz, Jr., M.D., and David P. Winchester, M.D./Chicago and Toledo, Ohio

Records from 229 total thyroidectomies over a 13-year period showed a 68% incidence of transient postoperative hypocalcemia (51% asymptomatic, 49% symptomatic), and a 2.9%-8.3% occurrence of permanent parathyroid insufficiency. No preoperative variables were found to identify those patients who would experience postoperative transient or permanent parathyroid insufficiency. The response of hypocalcemic symptoms to treatment with oral or parenteral calcium was unpredictable, with the exception of tetany.

Patients discharged on oral calcium had significantly prolonged hospital stays. The need for oral calcium supplementation could be predicted from the number of intravenous grams of calcium gluconate administered postoperatively. Earlier and more aggressive oral calcium replacement in this subgroup is recommended. Treatment protocols should be developed for the management of hypocalcemia following total thyroidectomy. These should include institution of fluid restriction for early asymptomatic hypocalcemia (presumably due to perioperative overhydration), administration of intravenous calcium for symptomatic patients, and definition of the lowest safe serum calcium level for the asymptomatic patient.

Parathyroid insufficiency following total thyroidectomy is a well-known complication with an incidence of 1%-30%.[1] The clinical manifestations of hypocalcemia are well documented, but the relationships between hypocalcemic symptoms and serum calcium levels and calcium replacement requirements have not been established. Consequently, treatment of postoperative hypocalcemia varies from physician to physician.

This study proposes to provide the clinician with a rational basis for predicting which patients will become hypocalcemic after total thyroidectomy, help to identify patients requiring treatment and suggest an appropriate treatment protocol.

Material and Methods

The records of 229 patients undergoing total thyroidectomy at our institution from 1968 to 1981 were reviewed. Postoperative management was the responsibility of the surgical housestaff under the supervision of the attending surgeon.

The variables investigated were: age, sex, previous history of radiation, pathologic conditions encountered, presence of parathyroid glands in the surgical specimen, type of operation performed, preoperative serum calcium, and all postoperative serum calcium levels. Normal serum calcium ranged from 8.5mg to 10.5mg per deciliter in our laboratory. Serum calcium levels were measured routinely the evening of operation and approximately every 12 hours thereafter. Symptoms of hypocalcemia which allowed assignment to a symptomatic subgroup were: Chvostek's sign, Trousseau's sign, circumoral or facial numbness, paresthesias of the extremities, generalized paresthesias, and tetany.

Based on the serum calcium level and the presence or absence of hypocalcemia symptoms, four patient subgroups were identified: (1) hypocalcemic-symptomatic, (2) hypocalcemic-asymptomatic, (3) eucalcemic-symptomatic, and (4) eu-

calcemic-asymptomatic.

The interval between the operation and the development of hypocalcemic symptoms was correlated with serum calcium levels and response to treatment. For each symptom, four possible outcomes were identified: (1) improvement with calcium, (2) improvement without calcium, (3) no improvement with calcium, and (4) no improvement, but not treated.

Permanent parathyroid insufficiency was defined as the need to continue oral calcium or vitamin D supplements more than one year after the operation. An attempt was made to identify preoperative factors which might be associated with this patient subgroup.

Table 1
Analysis of all patients

	Hypocalcemic Symptomatic N = (76)	Hypocalcemic Asymptomatic N = (80)	Eucalcemic Symptomatic N = (9)	Eucalcemic Asymptomatic N = (64)
Age	41.1	42.7	34.4	40.7
M/F	13/63 (17%/83%)	16/64 (20%/80%)	3/6	22/42 (34%/66%)
Neck Irradiation	49 (64%)	52 (65%)	9 (100%)	54 (84%)
Benign vs. Malignant	32/44 42%/58%	41/38 51%/49%	4/5	37/27 58%/42%
Extended Neck or Mediastinal Dissection	9 (12%)	3 (4%)	0	5 (8%)
Hospital Days (Average)	7.0	4.4	4.5	4.4
Parathyroid Glands in Dissection	21 (28%)	12 (15%)	2 (22%)	7 (11%)
% Treated	43 (56%)	9 (11%)	1 (11%)	0

Results

Of the 229 patients undergoing total thyroidectomy, 76 (33%) had symptomatic hypocalcemia, 80 (35%) had asymptomatic hypocalcemia, 64 (28%) were eucalcemic and asymptomatic, and nine (4%) had a normal serum calcium level with symptoms of hypocalcemia.

Forty-three of 76 symptomatic hypocalcemic patients were treated with intravenous or oral calcium. Nine of 80 patients with asymptomatic hypocalcemia received replacement therapy. No statistically significant correlation between postoperative hypocalcemia and age, sex, previous radiation history, benign or malignant disease, extent of operation, or preoperative calcium levels was found. (Table 1) Of the 76 hypocalcemic symptomatic patients, 21 (28%) had parathyroid tissue in the pathologic specimen. In contrast, 12 (15%) of the 80 patients with asymptomatic hypocalcemia had parathyroid tissue in the pathologic specimen ($X_3^2 = 7.408$; $0.05 < p < 0.10$).

Patients with symptomatic hypocalcemia had a significantly longer hospitalization (7.0 days) compared to other patient subgroups, which had a median stay of 4.5 days ($X_3^2 = 29.92$; $p < 0.001$). The lowest calcium level in hypocalcemic *asymptomatic* patients usually occurred on the day of the surgical procedure about 12 hours postoperatively; in *symptomatic* hypocalcemic patients, the lowest serum calcium level occurred between the second and third postoperative days.

In the 85 patients who developed symptoms of hypocalcemia, there were 51 episodes of paresthesias involving the upper extremities, 24 episodes of circumoral numbness associated with extremity paresthesias, and 20 instances of circumoral numbness alone. Chvostek's and Trousseau's signs, either alone or in addition to circumoral, extremity, or generalized paresthesias, were recorded on 71 occasions. Tetany was present in four patients. The tetany episodes occurred on postoperative day two (mean) and were associated with a mean serum calcium level of 7.2mg/dl.

Results of treatment of the symptomatic hypocalcemic patients are outlined in Table 2. Neither treatment with calcium, nor serum calcium level, predicted therapeutic result. Early occurrence of hypocalcemic symptomatology (*e.g.*, two days postoperatively) resulted in prompt resolution following supplemental calcium treatment. However, later-occurring symptoms (3-4 days) did not resolve with supplemental calcium.

On 15 occasions, nine hypocalcemic-asymptomatic patients were treated with calcium replacement between the first and second postoperative days. Four were discharged on oral calcium and vitamin D supplements.

Thirty-nine out of 76 hypocalcemic-symptomatic patients received oral calcium replacement in the hospital and 33 of this group were discharged on calcium supplements. Oral calcium supplementation was usually instituted on the third postoperative day and vitamin D on the fourth postoperative day. Vitamin D was administered to 16 of the 43 patients already on oral calcium. A total of 37 patients were discharged on calcium and/or vitamin D, with the average discharge at 9.5 days postoperatively.

Significantly, those requiring oral calcium supplementation had received an average of 4.4 ampules of intravenous calcium gluconate during their postoperative course. The patients who were treated with intravenous calcium and did not require subsequent long-term oral agents needed an average of only 1.3 ampules of intravenous calcium postoperatively ($X_1^2 = 19.37$; $p < 0.001$).

Long term follow-up was possible in 27 of 37 patients discharged on calcium and/or vitamin D. Of these, 18 no longer required oral calcium supplementation. Nine patients required long-term calcium replacement. All were female, six

Table 2
Outcome of Symptomatic Episodes in 76 Symptomatic Patients Following Total Thyroidectomy

	N (Episodes)	Ca++ Level at Time of Treatment (Mean)	Postoperative Day of Treatment (Mean)
1. Improved with Treatment	63	6.8mg/dl	2.1
2. Did Not Improve With Treatment	53	7.2	3.8
3. Improved in Absence of Treatment	47	7.2	2.0
4. Did Not Improve, No Treatment	26	7.4	3.7

had parathyroid glands in the pathologic specimen and seven had a malignant thyroid tumor. Three had a preoperative history of neck irradiation, and two underwent an extended mediastinal dissection. All of those patients who required permanent calcium replacement were from the hypocalcemic-symptomatic subgroup.

Discussion

The incidence of transient hypocalcemia after total thyroidectomy for cancer is reported at between 1%-59%.[1-3] Therefore, our incidence of transient postoperative hypocalcemia in 156 (68%) of 229 patients is not surprising; our incidence of *symptomatic* hypocalcemia was 33%. The mechanism of transient postoperative hypocalcemia was thought to be removal, or devascularization, of parathyroid tissue. Therefore, the hypocalcemic-symptomatic subgroup was expected to have a higher incidence of parathyroid glandular tissue in the pathologic glands of the patient. However, this difference was not statistically significant.

Another working hypothesis was that the highest incidence of extended neck or mediastinal dissection would be in the hypocalcemic-symptomatic group, but, the eucalcemic-asymptomatic group had a similar percentage of extended operations without accompanying hypocalcemia. In addition, preoperative neck irradiation, or a malignant tumor, might be expected to make dissection more difficult and lead to a higher incidence of subsequent hypocalcemia; this did not occur.

The lowest postoperative serum calcium level occurred between 48 and 72 hours after surgery in the hypocalcemic-symptomatic subgroup. This is the usual time for the postoperative calcium to reach its lowest value.[1,4] We question why the lowest postoperative serum calcium was seen during the first 24 hours in the hypocalcemic-asymptomatic subgroup. One possible explanation is overhydration during the intraoperative and early postoperative period. If a dilutional effect is postulated, the 80 hypocalcemic-asymptomatic patients could be discounted, and the transient postoperative hypocalcemia incidence would decrease from 68% to 33%. The fact that only nine of these 80 patients received calcium therapy while in the hospital and that none required permanent calcium replacement supports this hypothesis. Accordingly, hypocalcemia in the asymptomatic patient on the day of operation suggests dilutional hypocalcemia rather than true parathormone deficiency.

Generalized tetany was the only condition which was uniformly improved by administration of calcium. It occurred at postoperative day two (mean) with an average serum calcium of 7.2mg/dl. The improvement of circumoral, generalized paresthesias, or the disappearance of Chvostek's and Trousseau's signs following calcium therapy in only 54% was unexpected. Similarly, it was surprising that the symptomatic patients responding to calcium did not have a significantly lower serum calcium level than those who were unresponsive to calcium treatment. The improvement in symptoms of hypocalcemia could not be predicted on the basis of treatment with calcium or the serum calcium level at that time. Only the postoperative day of occurrence accurately predicted improvement.

The second postoperative day is the usual time for postoperative calcium to reach its nadir.[4] Our data indicate that, irrespective of treatment, patients who are symptomatic on postoperative day two will improve, while those whose symptoms occur between days three and four postoperatively will not show improvement, even if treated with supplemental calcium. It may be that the number of symptoms was not large enough to support the expected trend, or that the symptoms considered to be evidence of hypocalcemia are too subjective. Patient complaints of circumoral, extremity, and generalized paresthesias may be inadvertent responses to physician and nurse suggestion. This could have placed too many patients in the symptomatic subgroup instead of the hypocalcemic-asymptomatic group.

Thirty-three of 39 patients in the hypocalcemic-symptomatic subgroup and four of nine patients in the hypocalcemic-asymptomatic subgroup who were begun on oral calcium and/or vitamin D during their hospitalization, were discharged on one or both of these agents. The patients requiring oral calcium supplementation averaged 4.4 ampules of intravenous calcium gluconate postoperatively. This compares to the only 1.3 ampules of intravenous calcium for the symptomatic and asymptomatic-hypocalcemic subgroups not requiring oral supplements. Postoperative hospital stay might be significantly decreased if calcium replacement were begun after the second ampule of intravenous calcium, since it is these patients who are discharged on oral supplements and have a prolonged hospital stay.

The most striking observation in the hypocalcemic-symptomatic category is the prolonged hospitalization time (7.0 days). In addition, 43 of 76 hypocalcemic-symptomatic patients received intravenous or oral calcium replacement; 33

patients of this same group were discharged on oral supplements 9.5 days following total thyroidectomy.

It is difficult to explain why 33 patients with symptomatic hypocalcemia were not treated with supplemental calcium. The obligatory delay between the time the blood sample is obtained and the time the result is reported to the physician may explain this observation. Patients symptomatic at the time of the blood draw may have become asymptomatic by the time of the report. Also, the rather vague symptoms of circumoral or finger tingling may have been discounted in the absence of a more objective negative test for Chvostek's or Trousseau's signs.

Given that nine patients in the series required permanent oral calcium replacement and ten patients could not be followed, the percentage of permanent hypoparathyroidism is 3.9%-8.3%. This compares with a 0.6%-33%[1-10] incidence of permanent postoperative hypoparathyroidism following total thyroidectomy reported in the surgical literature.

Conclusion

No predictive variables were discovered to identify those patients who will experience transient or permanent parathormone deficiency and resultant hypocalcemia following total thyroidectomy. Tetanus was the only sign or symptom that was reliably corrected by administration of supplemental calcium. The varying responses to treatment have compounded the confusion leading to recommendation of a standard treatment protocol for hypocalcemia following total thyroidectomy.

Asymptomatic hypocalcemia in the first 24 postoperative hours probably is a reflection of overhydration, and need be treated only by fluid restriction. Close observation with serial serum calcium levels should also be instituted. However, *symptomatic* hypocalcemia should be treated, especially in the period of 48-72 hours following surgery. Asymptomatic hypocalcemia may be observed in a serial manner. Even in the absence of signs or symptoms, calcium supplementation should be instituted empirically at serum levels of less than 7.5mg/dl in order to avoid tetanus. Should any patient require a second ampule of intravenous calcium, one should also begin oral calcium supplementation at that time. Most of those patients will require oral calcium replacement at the time of discharge from the hospital; this will lead to an earlier discharge date for this group of patients. Thus, while approximately 19% of total thyroidectomy patients will receive calcium supplementation at the time of discharge, only 4%-8% will require these supplements for more than one year.

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David P. Winchester, M.D., is a board certified surgeon affiliated with Evanston Hospital, Evanston, as chief of the department of general surgery, head of surgical oncology, and associate director of the Kellogg Cancer Center. Dr. Winchester, an associate professor of clinical surgery at Northwestern University Medical School, Chicago, is a past president of the professional staff at Evanston Hospital. He is the director of the cancer department of the American College of Surgeons and is chairman of the American Cancer Society's Illinois Division early detection and prevention committee, the Task Force on Revising American Cancer Society Cancer Check-Up Guidelines and Society of Surgical Oncology's education committee.

Frank A. Baciewicz, Jr., M.D., is a board certified surgeon affiliated with the Medical College of Ohio, Toledo, as an assistant professor of surgery in the division of cardiothoracic surgery and director of surgical clerkships. Dr. Baciewicz completed a surgical internship and surgical residency at Northwestern University, Chicago. He is a member of the American College of Surgeons, Candidate Group, the Association for Academic Surgery and the International Society for Heart Transplantation.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Chronic alcoholism carries a risk of permanent hypogonadism with a permanent reduction in testosterone levels below 300 ng/dl. Low testosterone levels may be an additional risk factor for myocardial infarction, analogous to smoking, hypertension, and others. Aggressive behavior was noted in chronic alcoholics with low levels of testosterone. Large intakes of alcohol on a short-term basis may depress testosterone levels for short periods of time only. In chronic alcoholics the possible beneficial cardiovascular effects which may be obtained by testosterone supplementation must be weighed against the risks of carcinoma and aggressive behavior. (Swartz, C., Young, M.J.: *Am Geriatr Soc* 35:1,39-44, 1987)

Myofacial pains of the head and neck may be attributed to many causes, including pathologies in the temporomandibular joint. Conservative measures frequently improve the symptomatologies, but for persistent problems, transcranial lateral radiographs, tomograms, and arthrography may be needed. Plain radiographs determine joint space narrowing, subchondral cysts and spurs of osteoarthritis. Disc and other pathologies may require arthrography, tomography and magnetic reasonance imaging. (Piraino, D.: *Cleve Clin Q* 53:4,373-6, 1986)

A study on bone mass loss in postmenopausal women was undertaken to evaluate the physiologic effects of calcium supplementation alone, and of a combination of estrogen and calcium treatment. Losses of small significance were noted in the appendicular cortical skeleton bone mass in patients not receiving therapy or calcium. No significant changes were noted in women receiving estrogen and calcium. (Ettinger, B., *et al.*: *Ann Int Med* 106:1,40-5, 1987)

The authors studied 452 consecutive patients with one-vessel coronary lesions during exercise treadmill tests to determine the significance of ST and Q wave changes. ST depression occurred most frequently in leads V5 or V6, irrespective of which coronary artery was involved. In contrast to the nonspecific ST depression, patterns of ST elevation during exercise are a reliable guide to the underlying coronary lesion. Exercise-induced ST elevation without previous Q wave myocardial infarction may represent a possible left anterior descending vessel lesion. (Mark, D., *et al.: Ann Int Med* 106:1, 53-5, 1987)

Past treatment of focal cerebral ischemia was usually limited to aggressive anticoagulation and supportive measures. Methods to improve collateral blood flow and decrease neuronal energy requirements may lengthen the time during which jeopardized neurons can exist. Because of these methods, some neuronal damage is reversible under certain conditions. Medical and/or surgical intervention may be a better alternative than supportive measures alone. Measures discussed were systemic support for optimal cardiac circulation, hemodilution, anticoagulation, corticosteroids, calcium antagonists, barbiturates, perfluorocarbons, mannitol, naloxone, propanolol, superoxide dismutase, ascorbic acid, alpha-tocopherol, prostanoids and surgery. (Meyer, F., *et al.: Mayo Clin Proc* 62:1, 35-55, 1987)

In elderly patients who fall and subsequently require prolonged bedrest, an elevation of muscle enzymes may be misinterpreted as myocardial infarction; limb swelling may mimic deep vein thrombosis; and myoglobinuria may be mistaken for hematuria or hemoglobinuria. Rhabdomyolysis must be considered as an etiologic factor, and warrants a radioimmunoassay evaluation. Included as therapeutic measures are blood volume restoration, dopamine or diuretics for restoration of fluid balance, allopurinol and phosphate binding agents. Disseminated intravascular coagulation may require fresh frozen plasma. (Berman, P., Ratcliffe, P. *Ger Med Today* 5:12, 63-74, 1986)

Based on all available data, the Food and Drug Administration with its Advisory Committee on Fertility and Maternal Health Drugs has concluded that there is no need to revise the labeling of spermicidal products. Studies have not shown increased risks of birth anomalies from spermicide. The Kaiser Permanente prospective study on 30,000 women confirmed this conclusion. No chromosomal abnormalities were found in 612 infants born to mothers who had used spermicidal products after conception. (*FDA Drug Bulletin,* 16:2, 21-2, 1986)

Successful conservative treatments of metatarsal and heel pain consist of muscle stretching and strengthening of the ankles and intrinsic foot muscles, contrast baths to feet and use of nonsteroidal anti-inflammatory drugs to decrease edema and the inflammatory process, shoe modifications and orthotic devices. Steroidal injection may give immediate relief, but repeat injections may be deleterious. (D'Ambrosia, R.: *Orthop* 10:1, 137-142, 1987)

The relationship between plasma high-density lipoprotein cholesterol and testosterone levels was evaluated in adolescent boys, and also in those with delayed adolescence. These boys were given testosterone. As the blood testosterone level increased, the level of high-density lipoprotein cholesterol decreased. (Kirkland, R., *et al.*: *JAMA* 257:4, 502-7, 1987) ◀

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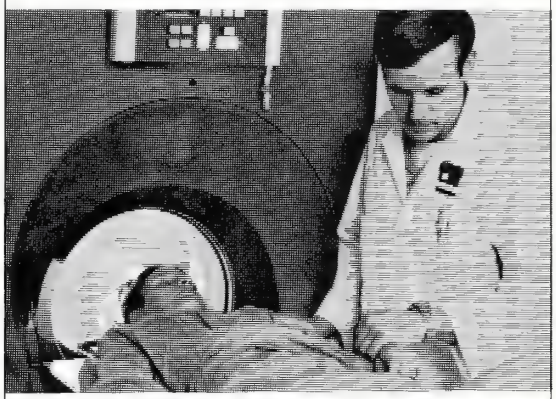
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OBITUARIES

***Buchholz, Alexander M.,** Hazel Crest, died January 11, 1987 at the age of 72. Dr. Buchholz was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

****Drever, Richard J.,** Sun City, Arizona (formerly of Oak Lawn), died January 6, 1987 at the age of 85. Dr. Drever was a 1929 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Joss, Edward F.,** Milwaukee, Wisconsin, died December 26, 1986 at the age of 83. Dr. Joss was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

***Kotcher, George P.,** Boerne, Texas, died January 16, 1987 at the age of 69. Dr. Kotcher was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

***Kremer, Ingeborg M.,** Columbia, died January 20, 1987 at the age of 64. Dr. Kremer was a 1947 graduate of the Medizinische Fakultat der Ludwig Maximiliams-Universitat, Munchen, Bayern, Germany.

****Kunsch, Ladislaus J.,** Naperville, died January 17, 1987 at the age of 81. Dr. Kunsch was a 1934 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Lange, Howard L.,** Belleville, died January 14, 1987 at the age of 83. Dr. Lange was a 1929 graduate of the St. Louis University School of Medicine, St. Louis.

***Lutwak, Asna H.,** Chicago, died January 11, 1987 at the age of 64. Dr. Lutwak was a 1949 graduate of the Medizinische Fakultat der Ludwig Maximiliams-Universitat, Munchen, Bayern, Germany.

****Pannabecker, Charles L.,** St. Petersburg, Florida, died January 18, 1987 at the age of 90. Dr. Pannabecker was a 1925 graduate of the University of Michigan Medical School, Ann Arbor.

***Qualmann, Lawrence R.,** Wadsworth, died January 30, 1987 at the age of 78. Dr. Qualmann was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

****Rhoads, Paul S.,** Richmond, Indiana, died January 24, 1987 at the age of 88. Dr. Rhoads was a 1925 graduate of Rush Medical College, Chicago.

****Segal, George M.,** Deerfield, died January 9, 1987 at the age of 93. Dr. Segal was a 1917 graduate of the Chicago College of Medicine and Surgery.

***Steiner, Bradford E.,** Northlake, died January 3, 1987 at the age of 69. Dr. Steiner was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

***Taylor, Daniel,** Springfield, died December 31, 1986 at the age of 31. Dr. Taylor was a 1982 graduate of the Southern Illinois University School of Medicine, Springfield.

****Wathier, Lawrence N.,** Geneseo, died January 5, 1987 at the age of 77. Dr. Wathier was a 1934 graduate of the University of Iowa College of Medicine, Iowa City.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Sunset Review '87

The Legislature Examines Illinois' Medical Practice Act

When the debate in the Illinois General Assembly heats up later this spring, Illinois physicians will have much at stake. Before the final gavel closes their 1987 session, lawmakers will have conducted a complete review of the Medical Practice Act—the major body of state law that governs the practice of medicine. Any changes made in the Act by the legislature can have a serious effect on a physician's ability to pursue his or her profession.

The Illinois Medical Practice Act is at the very heart of medical practice. It defines what it takes to obtain and maintain a license as a physician, and it specifies why and how that license may be revoked or restricted.

This year's review of the Medical Practice Act is mandated by "sunset" legislation passed by the General Assembly in 1979. At that time, the legislature directed that all existing Illinois laws governing professions, occupations, businesses, industries, and trades be reviewed every 10 years.

Regulatory acts governing each of these areas were assigned an expiration or "sunset" date on which they would expire without further action by the legislature. These sunset dates were staggered over a period of 10 years, and after each act is reviewed, another 10-year sunset date is imposed to force another review.

This year, it's the health sector's turn. In addition to the Medical Practice Act, eight acts governing health professionals are set to expire in 1987. Other professions experiencing sunset review are nurses, physicians' assistants, optometrists, podiatrists, pharmacists, nursing home administrators, psychologists, and social workers. Licensing acts for dentists and physical therapists were reviewed and extended by the General Assembly during its 1985 session.

Because of the Medical Practice Act's importance to each and every physician, the Illinois State Medical Society (ISMS) will take an active role in the debate that will surround the Act's extension. However, ISMS is urging all physicians to personally contact their legislators to impress upon them the need for adopting a piece of legislation that will assure continued quality medical care for Illinois residents.

ISMS is especially concerned that sunset review will open the Medical Practice Act to attempts by other groups to amend it in their own interests, but not in the interest of patients. For example, legislation has been introduced which would allow a pharmacist to decide which individual drug a patient should receive within a general class of drugs specified by the physician. Other allied health providers may seek to independently perform certain procedures that they may not be qualified to perform, and that are now considered part of the practice of medicine. Some consumer groups are pushing for an oppressive disciplinary system. Others are attempting to mandate Medicare assignment as a condition of licensure.

To aid physicians in their discussions with legislators about the Medical Practice Act, the *Illinois Medical Journal* is presenting the following information regarding the Act's major provisions and their ramifications. Physicians desiring additional information should contact ISMS at Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602; (312) 782-1654.

Licensure

The Medical Practice Act specifies that Doctors of Medicine (MDs) and Doctors of Osteopathy (DOs)—upon completion of acceptable educational and clinical training—will be licensed "to practice medicine in all of its branches."

Once licensed, physicians technically may practice in any specialty. Further state certification to practice a particular specialty is not required by state law.

Other provisions of the Medical Practice Act delineate what is needed for physicians already licensed in other states to obtain reciprocal authority to practice in Illinois. The Act also permits issuance of temporary certificates without completion of an examination to medical graduates who may be pursuing additional educational or specialty training. "Visiting professor" permits can be granted to physicians licensed in other states for practice limited to that necessitated by a faculty appointment at an Illinois medical school.

The practice of chiropractic also is regulated by the Medical Practice Act. The law is clear that their scope of practice is limited. In contrast to a physician licensed to practice medicine in all of its branches, chiropractors are authorized by the Medical Practice Act to "treat human ailments without drugs or medicines and without operative surgery."

Administration

The state agency charged with administering the Medical Practice Act is the Illinois Department of Registration and Education (DRE). Within the department's structure, two committees of physicians play a key role:

- The Medical Practice Examining Committee supervises the licensure process, including: (1) specification of required education and training; (2) determination as to which educational institutions provide training of a sufficient quality to warrant licensure; and (3) development and administration of medical examinations.
- The Medical Disciplinary Board oversees the disciplinary process, including: (1) investigation of complaints against physicians, chiropractors, and physician assistants; (2) recommendations regarding the revocation, suspension, or restriction of a physician's license; and (3) monitoring of physician compliance with restrictions placed on his or her ability to practice.

Physicians serving on the Medical Practice Examining Committee are appointed by the Director of the Department of Registration and Education. Members of the Medical Disciplinary Board are appointed by the Governor with the advice and consent of the Illinois Senate.

Fees

Fees for initial and renewal licenses are also dictated by the Medical Practice Act. Under an amendment to the Act sought by the Illinois State Medical Society, funds received by the Department of Registration and Education from license renewals are earmarked to pay the administrative costs associated with the renewal process and to fund the operation of the Medical Disciplinary Board.

Additional increases in physician licensure fees are being sought by at least one consumer activist group. The group is advocating use of the extra funds to increase the number of medical investigators that DRE retains to pursue complaints.

The Illinois State Medical Society has indicated that it is not opposed to increased fees if a case can be made for further improvements in the disciplinary system. While additional investigators may be necessary, ISMS maintains that the real issue is better training to improve the effectiveness of investigators. ISMS has offered its assistance to DRE to help the department train its investigators.

Discipline

A major portion of the Medical Practice Act focuses on measures to discipline physicians who engage in unethical, illegal, or incompetent practices.

At the core of these disciplinary provisions are those that relate to the Medical Disciplinary Board. Laws creating the Disciplinary Board were passed as amendments to the Medical Practice Act in 1975 at the behest of the Illinois State Medical Society.

ISMS originally proposed a strengthened disciplinary system in 1972, but was thwarted by the opposition of then-Governor Daniel Walker and his appointee to the post of Director of the Department of Registration and Education. Undaunted by this opposition, the Society continued to pursue a stronger disciplinary system until the General Assembly was persuaded to override Governor Walker's veto of the ISMS-backed amendments.

The Medical Disciplinary Board

The Medical Disciplinary Board is responsible for overseeing investigations into charges against a physician, conducting hearings regarding the findings of those investigations, and, if warranted, recommending disciplinary action to the Director of the Department of Registration and Education.

To protect the reputations of those physicians against whom complaints later prove unfounded, the investigations and initial screening proceedings of the Disciplinary Board are confidential. However, any formal hearings or sanctions ultimately imposed against a physician become a matter of public record.

The Disciplinary Board may recommend to the Director of the Department of Registration and Education that a physician's license be revoked, suspended, or placed on probation, or that a reprimand be issued. In addition, the Disciplinary Board may recommend that some restriction—such as a prohibition against prescribing drugs—be placed upon the physician's authority to practice. Recommendations for additional educational training or participation in a drug abuse treatment program are also possible Disciplinary Board actions.

If the DRE Director fails to act on the Medical Disciplinary Board's recommendations, he or she must file a written explanation with the Disciplinary Board and the Illinois Secretary of State. Conversely, the Director is empowered by the Medical Practice Act to temporarily suspend a physician's license without a Disciplinary Board hearing if a danger to the public is deemed to exist. However, the Disciplinary Board must review the Director's action on an expedited basis.

The Medical Disciplinary Board is appointed by the Governor. Seven MDs, one osteopath and one chiropractor compose the voting

board, with two non-voting public representatives also appointed.

The law also provides for the hiring of a Medical Coordinator to assist the Board and to serve as chief enforcement officer of the Medical Practice Act. Also provided for are at least one trained investigator for each 5,000 physician licenses granted. Investigators must be college graduates with at least two years of investigative experience or at least one year of advanced medical training.

The Illinois State Medical Society—through a special task force on improving the disciplinary system (see accompanying story on page 154)—has suggested that the Department of Registration and Education be empowered to hire a second medical coordinator to facilitate the disciplinary process. The Society also has repeatedly offered its services to DRE with the goal of improving the training of medical investigators.

Grounds for Action

To guide the Medical Disciplinary Board in its investigations and deliberations, the Medical Practice Act defines the grounds upon which a physician may have his or her license revoked, suspended, or restricted. Some 26 categories are listed as grounds for disciplinary action:

1. Performance of an elective abortion in other than an appropriate health facility;
2. Willful and wanton performance of an abortion on a woman who is not pregnant;
3. Conviction of a felony;
4. Gross or repeated malpractice that results in serious injury or death;
5. Dishonorable, unethical, or unprofessional conduct that results in serious injury or death;
6. Obtaining a fee for a fraudulent promise that an incurable condition can be permanently cured;
7. Habitual use of alcohol or drugs that prevents the physician from performing his or her professional duties;
8. Treating human ailments under any name other than

Consumer Groups' Agenda

Mandatory Medicare Assignment, Stricter Discipline Sought

The General Assembly's consideration of the Medical Practice Act under sunset review will present the opportunity for interest groups outside the medical profession to offer amendments of their own.

To date, at least one coalition of consumer, union, and trial attorney organizations is advocating legislation that would force physicians to accept Medicare assignment as a condition of licensure and revise disciplinary provisions of the Medical Practice Act.

The coalition has charged that "state action against incompetent and negligent physicians is so infrequent that bad doctors go virtually unpunished in Illinois." Responding to the charges, Illinois State Medical Society President Dr. Jere E. Freidheim called the group's study of disciplinary actions "misleading and riddled with error." Dr. Freidheim suggested that the attack on physician discipline might be a strategy employed by opponents of the medical profession's legislative proposals for further malpractice reform.

A summary of the consumer/trial attorney proposals and the medical community's response follows:

- *The consumer/trial attorney coalition* proposes raising the annual fee for a medical license to $500 a year to finance increased regulatory staff for the Illinois Department of Registration and Education (DRE). The group wants to reduce the minimum ratio of DRE's medical investigators to licensed physicians from 1:5,000 to 1:400.

  Physicians see a need to improve the training of investigators, and ISMS has offered its assistance to DRE in this task. While there may be a need to add some investigators, arbitrarily increasing the number of investigators would increase bureaucratic red tape with no effect on the quality of medical care provided.

- *The consumer/trial attorney coalition* is proposing that DRE be required to review each physician's file every other license renewal period to prevent malpractice suits and disciplinary actions from being overlooked.

  Physicians agree that disciplinary situations involving a physician should be reviewed. However, such review should take place on an ongoing rather than intermittent basis. The proposals advocated by the consumer/trial attorney coalition in this area are superfluous, since mechanisms already exist to provide automatic review of mandatory reports and complaints referred to the Department of Registration and Education.

- *The consumer/trial attorney coalition* is proposing that

physicians periodically be required to pass a recertification exam before a medical license is renewed.

Physicians believe re-examination is also an unnecessary requirement. Various medical specialty organizations require continuing education and examination for specialty certification, and physicians have an exemplary record in pursuing voluntary continuing medical education.

- *The consumer/trial attorney coalition* proposes requiring that information collected by Peer Review Organizations be incorporated into DRE physician files.

  Physicians believe that the effectiveness of peer review depends upon confidentiality. Truly candid peer review would be eliminated if information was disseminated beyond the local level.

- *The consumer/trial attorney coalition* is demanding professional counseling and urinalysis for physicians who are put on probation for substance abuse. A positive test would result in summary suspension of a physician's license. The coalition also would like to eliminate a current provision in the law that permits purging any record of a substance abuse problem when the physician is deemed rehabilitated.

  Physicians believe the provisions now governing impaired practitioners are fair to patient and doctor alike, and are working. We are supportive of efforts to direct impaired physicians into treatment. Impaired physicians are restricted, and every effort is made to restore them to good health while protecting the public with monitoring mechanisms. In addition, the Board currently has the authority to order physicians to undergo a clinical or psychiatric evaluation.

- *The consumer/trial attorney coalition* would require DRE to increase consumer access to nonconfidential information using such techniques as a toll-free number and an annual report on disciplinary actions taken.

  Physicians believe such mechanisms are unnecessary. DRE already makes public its disciplinary actions through monthly reports, and consumer representatives hold memberships on the Disciplinary Board.

The coalition is using its proposals on medical discipline to counter the medical profession's measures to cap noneconomic damage awards in malpractice cases. Charging that physicians "want to punish the victims, not their incompetent colleagues," the group maintains that physicians are opposing any serious reform of the law governing physician discipline. Instead, they want to reduce their insurance costs by limiting their patients' right to sue, according to the consumer coalition.

Physicians have countered that they want to improve medical discipline and the legal system. The medical profession believes restoring balance to the legal system is the key to reducing the increase in health care costs for patients. ISMS joined with Governor Thompson last year to form a Task Force on Medical Discipline which recommended concrete improvements in the disciplinary system. ◀

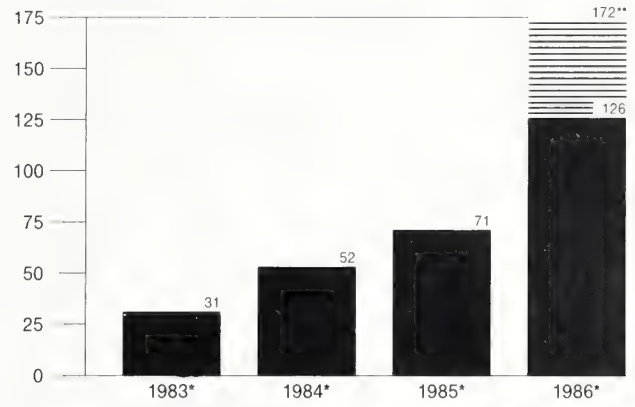
the physician's own;
9. Fraudulently obtaining a license, certificate, or permit to practice;
10. Making false statements about one's skill or the efficacy of a treatment;
11. Associating with another person or firm that is engaged in a practice that is illegal under the Medical Practice Act;
12. Revocation or suspension of a medical license in another state;
13. Any violation of the provisions of the Medical Practice Act or regulations developed to administer the Act;
14. Giving or receiving fees for services not personally rendered, except as allowed under laws governing medical partnerships and corporations;
15. Violation of any terms of disciplinary action imposed against a physician;
16. Abandonment of a patient;
17. Use of or prescribing narcotics for other than therapeutic purposes;
18. Promoting the sale of drugs or devices to exploit a patient for financial gain;
19. Offering or agreeing to cure or treat a disease by a secret method which the physician refuses to divulge upon demand of the Department of Registration and Education;

20. Immoral conduct in practice as a physician or repeated acts of gross misconduct;
21. Willfully making false reports or records;
22. Willfully failing to file medical reports required by law or willfully failing to report an instance of suspected child abuse or neglect;
23. Soliciting professional patronage by any firms which will profit from representing themselves as agents of the physician;
24. Gross, willful, and continued overcharging for professional services, including charging for services never rendered;
25. Professional incompetence as evidenced by poor standards of care or mental incompetency;
26. Physical illness which hampers a physician's ability to practice medicine with reasonable judgment, skill, or safety; and
27. Causing a child to be an abused or neglected child as defined in the Abused and Neglected Child Reporting Act.

In 1986, a total of 126 disciplinary actions were taken against Illinois physicians—a 77 percent increase over those in the previous year. (See accompanying chart.) These actions included 18 revocations, 73 suspensions, 28 instances of probation, one reprimand, and six other restrictions. In addition to the 126 actions, 46 less serious sanctions—such as warning letters—were imposed.

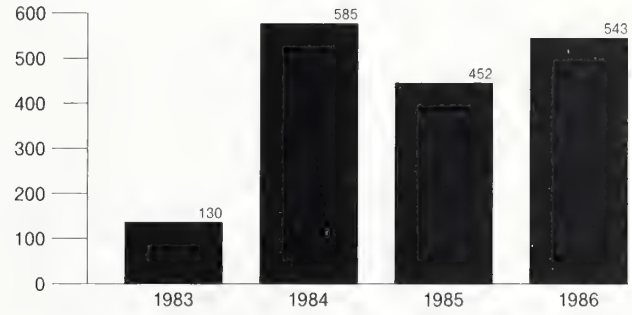
Recently, the Illinois State Medical Society has advocated clarifying some of the existing grounds for disciplinary action. The Society also suggests adding other grounds, including a broadened definition of "gross malpractice," and such acts as cheating on medical licensing exams, violating patient confidentiality, sexual abuse, and drug prescribing violations.

Medical Discipline in Illinois
(As of December 31, 1986)
Disciplinary Actions Against Medical Practitioners



*1983- 14 complaints still pending
*1984- 26 complaints still pending
*1985- 40 complaints still pending
*1986-228 complaints still pending
**Includes lesser actions considered disciplinary actions by other states

Medical Discipline in Illinois
(As of December 31, 1986)
Mandatory Reports



Mandatory Reporting

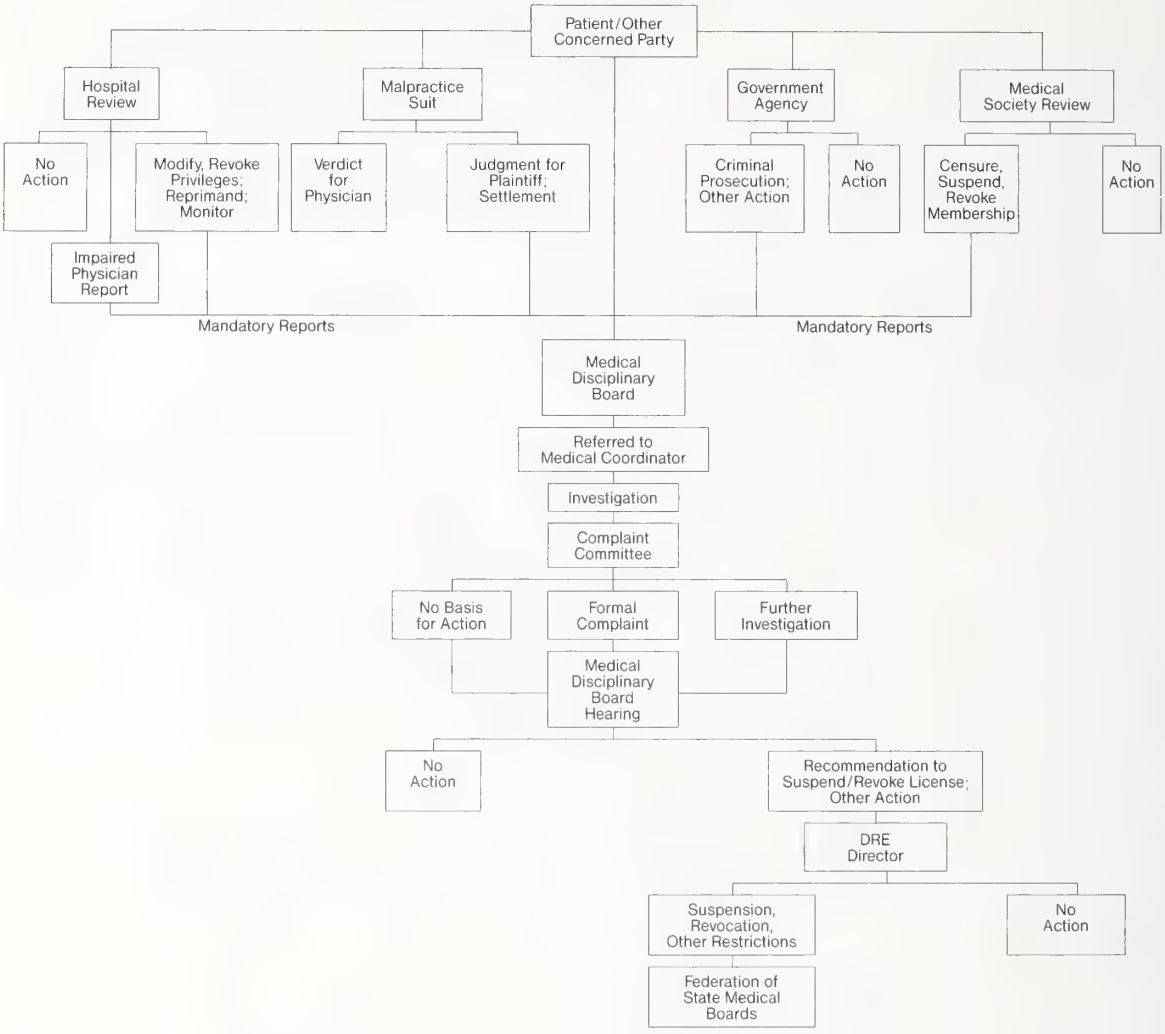
The disciplinary provisions of the Medical Practice Act also contain a "mandatory reporting" section which requires certain entities to report official sanctions taken against a physician. These provisions were added to the Act in 1983 when ISMS offered them to the General Assembly.

Under mandatory reporting, hospitals and other health care institutions must report to the Disciplinary Board any restriction or termination of a physician's hospital privileges due to unprofessional conduct. Physicians with mental or physical disabilities that endanger a patient also must be reported.

The Illinois State Medical Society, county medical societies, and other professional associations must report final actions affecting a physician's membership standing that result from incidents of unprofessional conduct.

Other reports that must be made to the Disciplinary Board include the following:

DISCIPLINARY PROCESS FOR UNPROFESSIONAL OR CRIMINAL CONDUCT



- Professional liability insurers must report any malpractice case settlements or judgments in favor of a plaintiff.
- States attorneys must report any felony convictions of a physician.
- State agencies, including officials of the Department of Registration and Education, must report any violations of the Medical Practice Act, incidents of unprofessional conduct, and mental or physical disabilities that endanger patients.

The Medical Disciplinary Board also receives reports concerning physicians placed on supervision due to impairment of abilities resulting from drug or alcohol abuse or other conditions. Physicians who have been clinically determined to be impaired are immune from disciplinary action while under treatment and supervision. However, the Disciplinary Board is empowered to rule upon the acceptability of the physician's treatment program, and can demand regular reports regarding the physician's progress. Physicians who fail to adhere to supervision provisions can be treated as disciplinary cases by the Disciplinary Board.

In all mandatory reporting cases, immunity from prosecution is provided for anyone making a report against a physician in good faith.

A total of 543 incidents were reported to the Medical Disciplinary Board under the mandatory reporting provisions in 1986 (see accompanying chart on page 151). Of those, 13 resulted in disciplinary actions. Some 349 cases were closed without any action taken against the physician involved, and 181 cases were still pending as of December 31.

Other Provisions

The Medical Practice Act also contains other provisions that relate to medical practice. For example, exemptions from civil liability are provided to physicians who:

- Provide for no fee emergency care without prior notice of the illness or injury;
- Provide care free of charge to all their patients and receive no income whatsoever from the practice of medicine.
- Serve in good faith on medical society or hospital committees involved in improving the quality of patient care or professional discipline; or
- Report violations of the Medical Practice Act's professional advertising stipulations.

The act also addresses physicians who dispense drugs, requiring such practitioners to meet certain labeling requirements. ◂

Mandatory Assignment No Solution to Medicare Woes

Since its enactment in 1965, virtually every U.S. Congress has tinkered with the provisions of the Medicare law. This year, however, suggestions have been made that the state legislature address Medicare-related issues as part of its sunset review of the Medical Practice Act.

Self-designated consumer advocates have urged the General Assembly to adopt legislation mandating physicians to accept Medicare "assignment" as a condition for licensure in Illinois. Only one other state—Massachusetts—has approved mandatory assignment, and court challenges have left its legal status there still in doubt.

The Illinois State Medical Society believes that mandated assignment holds potentially dangerous consequences for physicians and the elderly patients they treat. Mandatory assignment is not only a false solution for Medicare cost containment, but another irritant to an already ailing system.

Under mandatory assignment, all physicians would have to accept the government-determined "reimbursement" for each and every Medicare patient they treat.

Mandatory assignment means that physicians treating Medicare patients must accept government-determined reimbursement for *each and every Medicare patient they treat.* Since 1984, Medicare has regulated reimbursement to Illinois physicians through a complex system that takes into account the physician's practice location, fees charged in past years, and other factors. Because the Medicare program has failed to raise reimbursement levels to keep pace with inflation, Illinois currently has only a small number of "Medicare-participating" physicians—those who agree to accept assignment from the federal government for 100% of patients they treat. As of year-end 1986, only 22% of Illinois physicians and Medicare suppliers did so.

Even those doctors who have refrained from "participating" have seen strict controls on their Medicare reimbursement. Although physicians who do not accept assignment all the time may receive slightly higher reimbursement, they are still not free to charge Medicare patients "the going rate" for health care services. However, doctors not participating in Medicare *can* bill patients for the difference between the controlled fee of a participating physician and the higher—but still controlled—fee of a non-participating physician.

Physicians are sensitive to the financial constraints their patients face. And many accept Medicare reimbursement as payment in full when the patient's financial situation warrants it. About two-thirds of all Illinois Medicare claims are assigned. However, most physicians are unwilling to let the government totally dictate fees at a time when medical practice costs continue to rise.

ISMS believes mandatory assignment will hurt Illinois patients. A physician faced with state disciplinary action for failing to accept Medicare's fee levels may simply choose not to treat any Medicare patients. The onset of mandatory assignment also will force physicians and other health care professionals competing in the marketplace to seek out other, younger classes of patients. Specialties focusing upon care of the aged may find their future ranks dwindling. As a result, elderly patients will soon find their access to health care limited.

Like businessmen, physicians must pass on the costs of doing business to their customers. Mandated Medicare assignment will not cut costs, but will merely shift them broadly to all Illinois health care consumers. Illinois businesses, consumers and anyone who shares in paying health care costs will carry this extra burden.

In addition, the amount the federal government arbitrarily decides a physician may be reimbursed by Medicare should have absolutely no bearing on the quality or credentials of a physician. Medical licensure is a privilege founded upon medical education and skill—not upon physician billing practices.

Congress has afforded physicians the choice of participating in the Medicare assignment system. This freedom, granted under federal law, must be preserved for Illinois physicians and patients. Mandatory assignment will destroy the choice of both physician and patient in the health care arena, and ISMS intends to unequivocally oppose any move toward mandatory assignment as a condition of licensure in Illinois. ◂

Improving the Disciplinary System

Since 1983, annual Medical Disciplinary Board actions against physicians have increased 306 percent—a signal of the system's growing effectiveness. Nonetheless, recognizing the importance of a medical disciplinary system that patients and the general public can have confidence in, the Illinois State Medical Society has continued to study the state's system for handling of complaints against physicians.

Last year, representatives of the Society's physician leadership worked with Illinois Governor James R. Thompson to create a special Task Force on Medical Discipline. The task force brought together physicians, representatives of the Governor, and Illinois Department of Registration and Education administrators to study problems and propose solutions. Following are some of the recommendations offered by the task force:

1. *Steps must be taken to eliminate procedural obstacles to investigations by the Medical Disciplinary Board.*

   The statute of limitations for disciplinary action should be lengthened to allow adequate time for thorough investigations. Allegations made by other state agencies should receive expedited handling. A second medical coordinator post should be established to ensure swift action in all investigations.
2. *Better communication and tracking should be achieved with respect to impaired physicians.*

   Information regarding an impaired physician's progress should be shared between the Disciplinary Board and the medical staff of the hospital at which the physician practices. Physicians being monitored by the Disciplinary Board for an impairment problem should undergo automatic review if they remove themselves prematurely from therapy programs.
3. *A roster of physician experts in each specialty should be made available to the Disciplinary Board's medical coordinator for screening and investigating complaints.*
4. *A special board of physician clinical examiners should be available to examine the clinical competence of certain physicians under investigation by the Disciplinary Board.*
5. *Coordination with other state and national governmental agencies should be improved, and hospitals should be obliged to aggressively search out any previous action taken against a physician's license.*

   Physicians who are disciplined or barred from practice in one state must be prevented from obtaining a license and hospital privileges in Illinois without proper review.
6. *The Medical Disciplinary Board should have limited access to the medical records of patients involved in incidents that trigger a mandatory report.*

   The lack of complete medical records often makes it impossible to pursue complaints. Although the Disciplinary Board should have access to the medical information, provisions should be made to guarantee confidentiality with respect to the patient.
7. *The Medical Disciplinary Board should be granted authority to initiate investigations in the absence of a complaint and to order inspection of a physician's office.*
8. *Current grounds for discipline need to be expanded and clarified.*

   For example, "gross malpractice" should be redefined to eliminate serious injury or death as necessary before action can be taken. And other examples of misconduct should be added to the list of actionable offenses, including: cheating on medical license exams; violating patient confidentiality; sexual abuse or misconduct; improper prescribing, selling, or administering controlled substances; a *repeating* pattern of incompetent practice; and failure to report previous disciplinary actions in other licensing jurisdictions.

   Also, a new set of disciplines, such as a series of fines, should be developed to punish physicians for improper business practices that inconvenience, but do not harm, patients.
9. *Improvements should be made in the training of medical investigators to increase their effectiveness in pursuing complaints against physicians.*

ISMS intends to seek these and other improvements in the disciplinary system through action by the Illinois General Assembly. Some of these issues may arise during debate over sunset review of the Medical Practice Act during the legislature's 1987 session. ◀

Nine Health Professions Reviewed

A total of nine laws governing health professionals in Illinois are up for sunset review by the General Assembly. Under the terms of the Illinois Regulatory Sunset Act of 1979, action must be taken during the 1987 legislative session on these laws or they will expire automatically.

A chief function of each of the health acts up for review is to define the types of activity in which persons licensed or certified under the respective act may engage. For example, the Medical Practice Act authorizes doctors of medicine (MDs) and doctors of osteopathy (DOs) to "practice medicine in all of its branches." In contrast, the Medical Practice Act defines chiropractic as "treating human ailments without drugs or medicines and without operative surgery."

Debate surrounding the licensing of various health professionals may include attempts to expand the scope of practice for some groups. To assist physicians in participating in this debate, the following material is a summary of the major practice definitions that are contained in the health licensing acts up for review.

Nurses

The Illinois Nursing Act defines both "registered" and "practical" nurses. Registered nurses are permitted to: (1) evaluate, observe, care for, and counsel the ill, injured or infirm; (2) work to maintain health or prevent illness in others; (3) administer medications and treatments prescribed by physicians and dentists; and (4) supervise or teach nursing. Practical nurses may—under the direction of a registered nurse, physician, or dentist—care for the ill, injured, or infirm.

Nurses are not permitted to diagnose medical conditions. Nor may they prescribe therapeutic or corrective measures which are performed only by licensed physicians.

Physicians' Assistants

A physician's assistant (PA) is certified to perform medical procedures under the supervision of a licensed physician. The assistant may perform such procedures that are within the specialty of the supervising physician and carried out under the direct supervision and control of that physician. A physician's assistant may not exercise independent judgment for the diagnosis and treatment of medical conditions. The law currently prohibits a PA from practicing independently and requires that he or she be employed by a physician, correctional facility, or state mental facility.

Optometrists

Optometrists are permitted to examine the human eye and its appendages to ascertain abnormal conditions, measure vision, adapt lenses or prisms to improve vision, adapt or fit contact lenses, and prescribe ocular exercises or other visual training. Optometrists are not allowed to use drugs, except for topical agents used for diagnosis. If an optometrist discovers an indication of disease or a condition that requires treatment outside the scope of the optometrist's practice, he or she is required to refer the patient to a fully-licensed physician.

Podiatrists

Podiatrists (also known as chiropodists) are licensed to diagnose and treat ailments of the human foot. Unlike chiropractors, podiatrists are permitted to use drugs and surgery. However, they are not permitted to use general anesthesia, nor may they perform amputations of the foot.

Pharmacists

The practice of pharmacy is defined by law to include the compounding, dispensing, and selling of drugs and medicines prescribed by licensed physicians, dentists, veterinarians, and other authorized persons. Pharmacists also may recommend or advise consumers about the contents, therapeutic values, and uses of prescribed drugs.

Psychologists

The practice of psychology is defined as the application of established principles of learning, motivation, perception, thinking, and emotional relationships to problems of behavior adjustment, evaluation of persons and group relations by persons trained in psychology. Such applications include: (1) counseling; (2) measuring and testing of personality, intelligence, aptitudes, public opinion,

attitudes, and skills; (3) teaching of such subject matter; and (4) conducting research on problems relating to human behavior.

Social Workers

Social workers are issued certificates of registration by the state to render services in the fields of social casework, social group work, community organization for social welfare, social work research, social welfare administration, or social work education.

Nursing Home Administrators

A nursing home administrator is licensed and defined as the individual responsible for planning, organizing, directing, and supervising the operation of a nursing home. Nursing homes are defined by the law to include private homes, institutions, buildings, residences, or other places which provide maintenance, personal care, and nursing for three or more persons who are not related to the owner. Such facilities must be licensed by the Illinois Department of Public Health.

Other Practitioners

The Medical Practice Act once permitted the granting of licenses to practice midwifery. However, current law no longer provides for issuance of such licenses.

Other classes of health practitioner exist, but are less defined under Illinois law. For example, recent court activities have made unclear the Medical Practice Act's applicability to naprapaths and acupuncturists. Neither practitioner is defined by law, leaving education and training requirements as well as responsibilities hazy. Naturopaths and masseuses are other categories unregulated by a licensing or certification law. ◂

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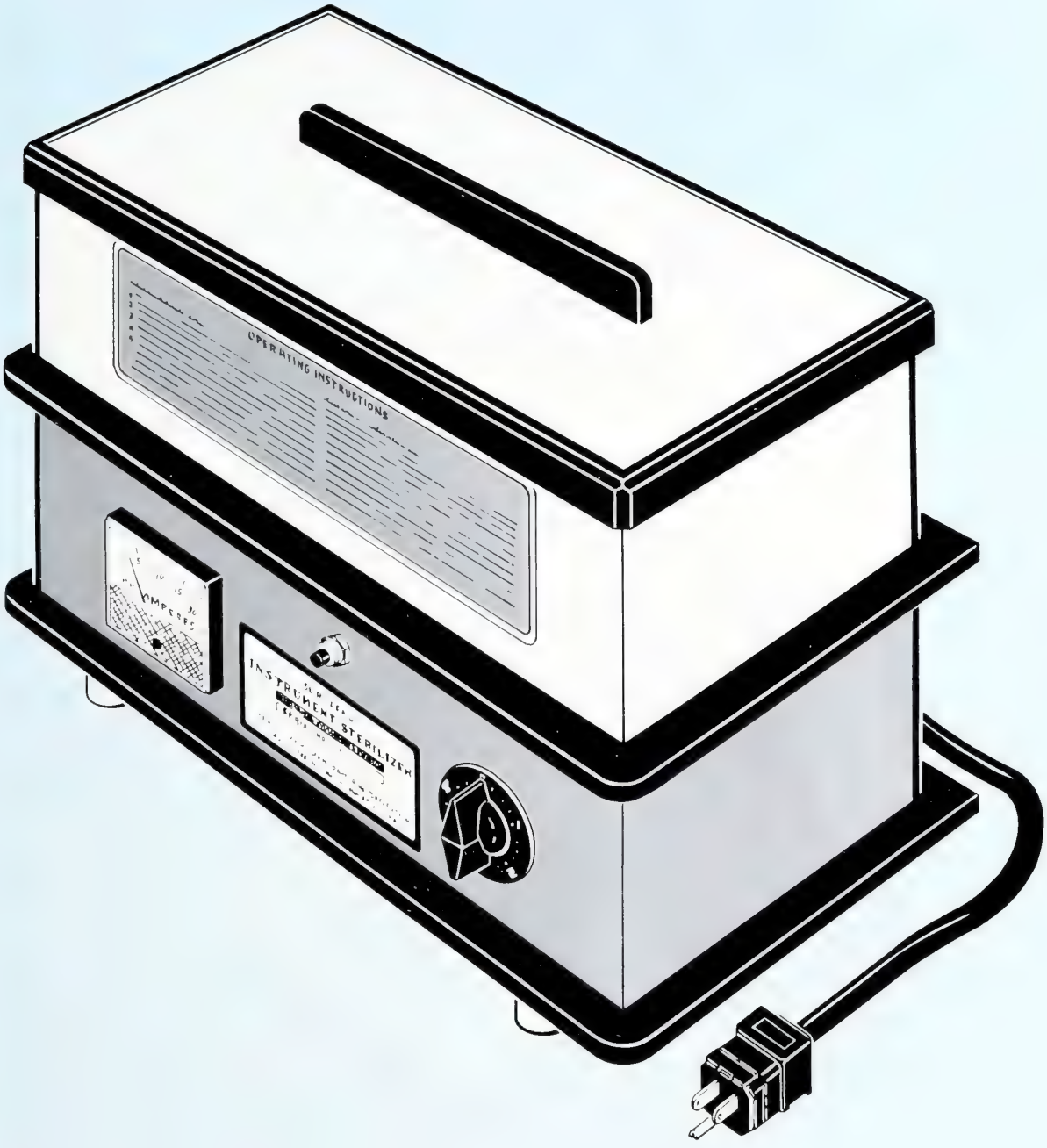
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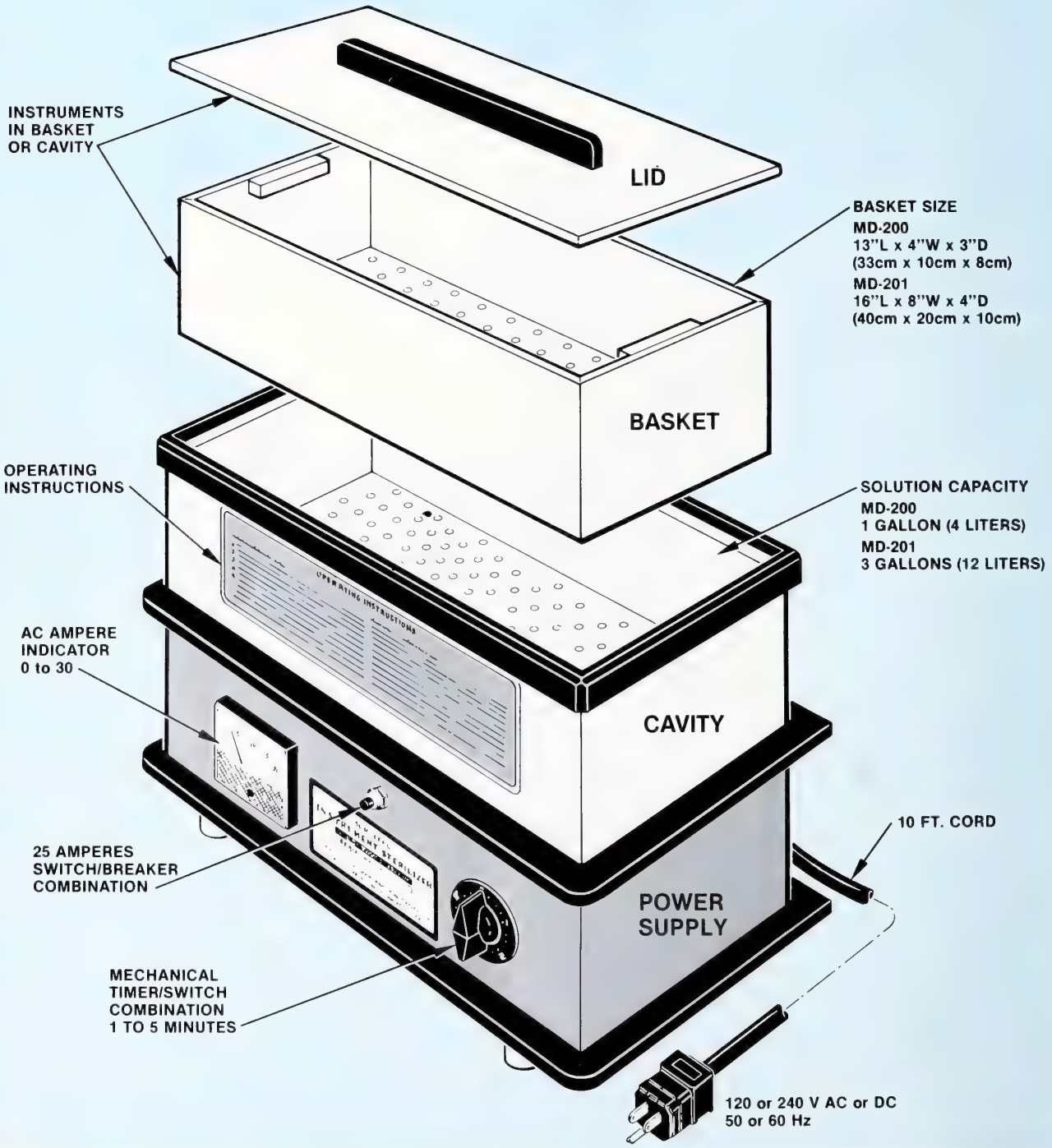
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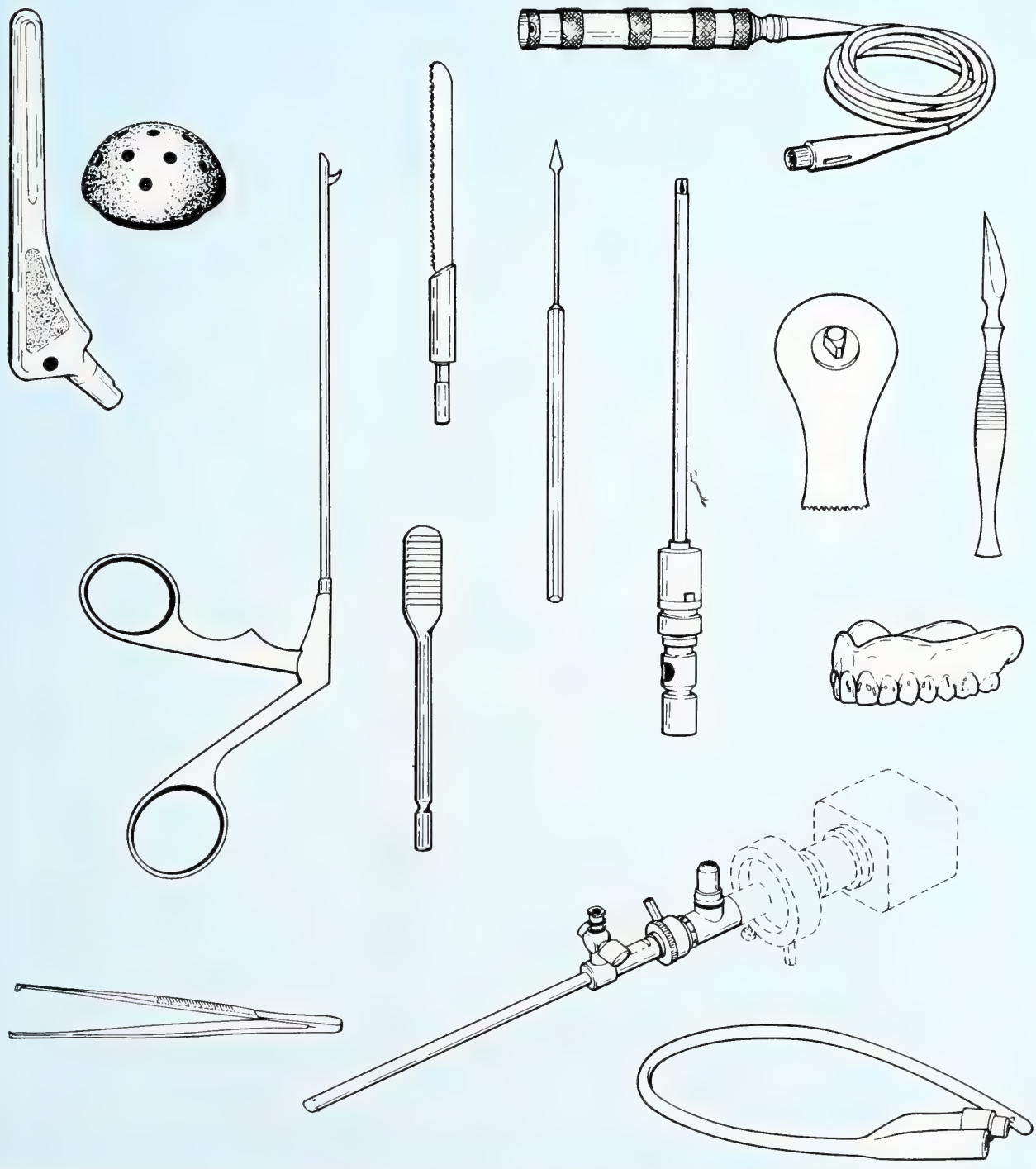
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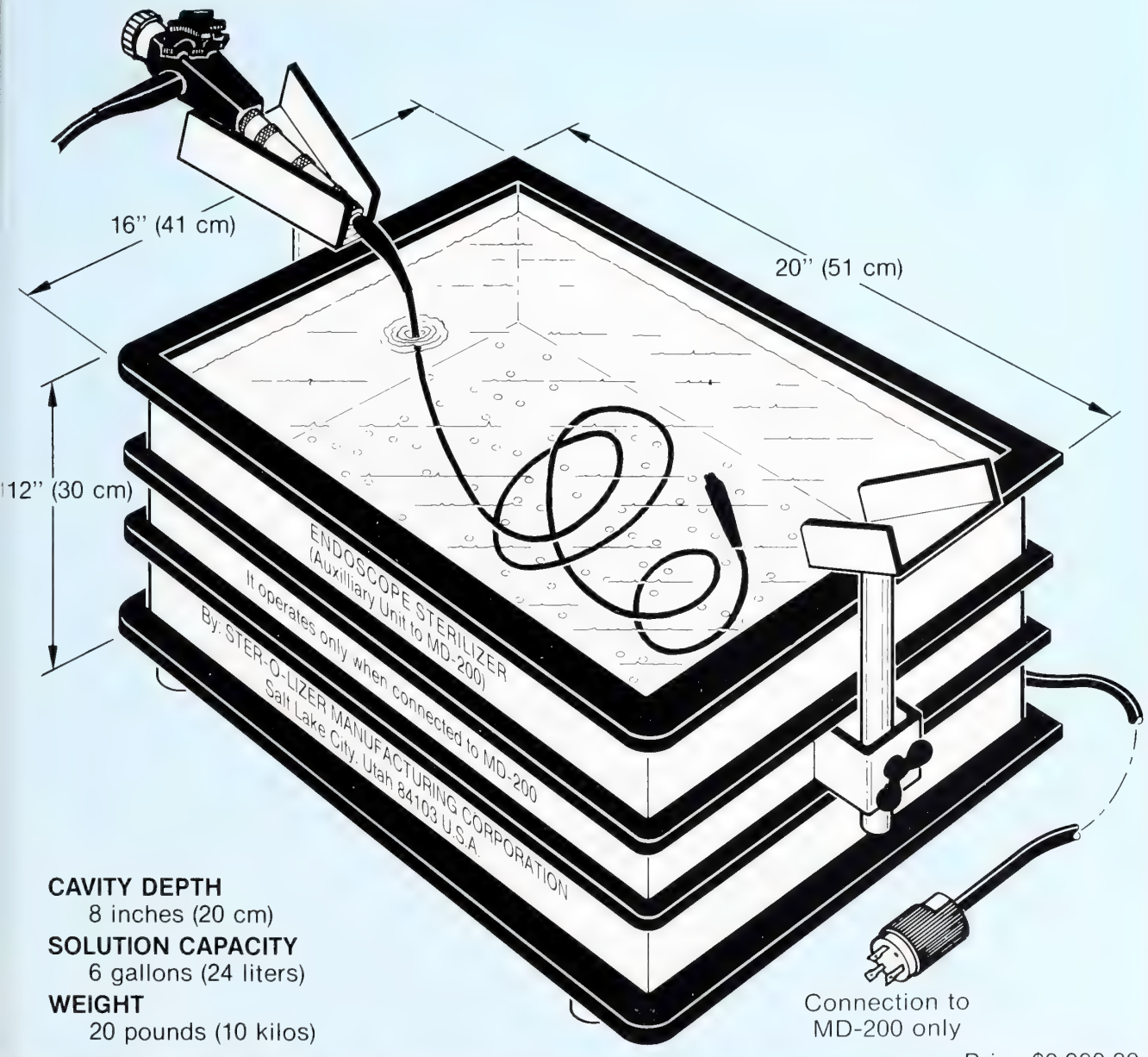
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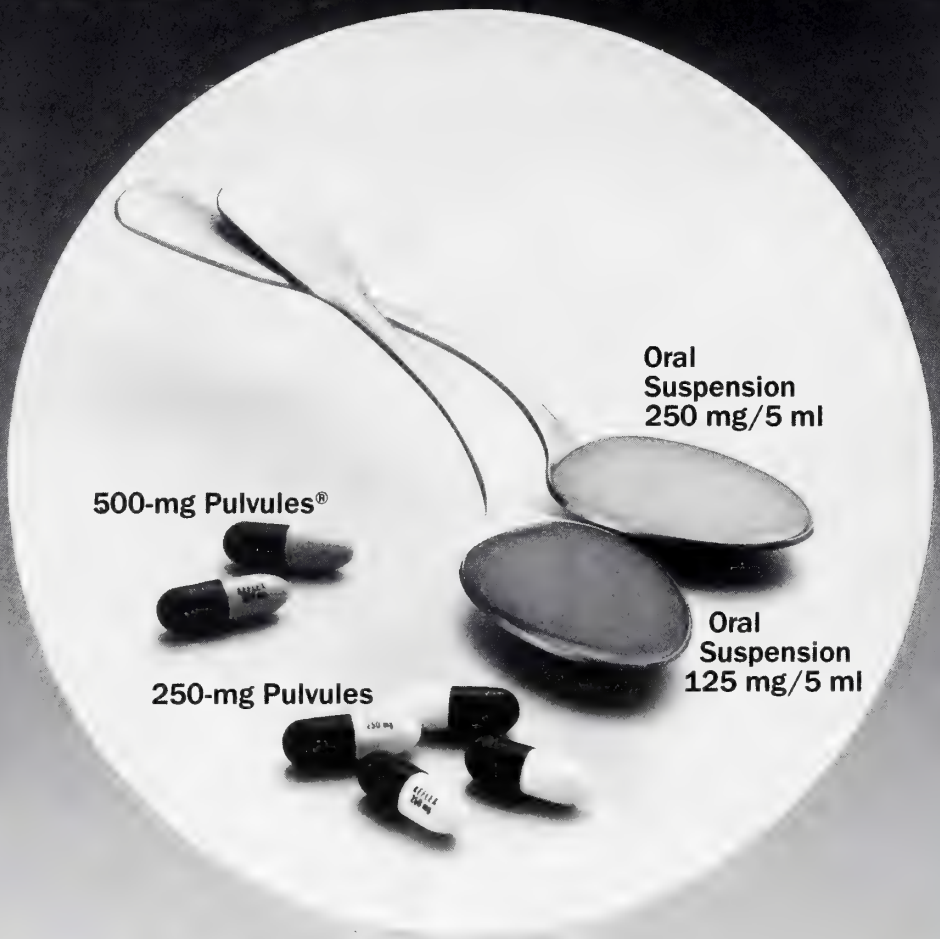
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	County	*Delegates*	*Alternate Delegates*
	Jackson	Roger N. Klam	Antoinette Thomas
	Jefferson-Hamilton	Charles K. Wells	
	Massac	Benito C. Bajuyo	Bharat Patel
	Saline-Pope-Hardin	Larry R. Jones	Alexander Z. Goldstein
	Union	Carroll Loomis	
	Wabash	Donna Gamble	Thomas Farney
	Wayne		T. S. Agustsson
	White	Phillip D. Boren	
	Williamson	George B. Murphy	Robert D. Kane
District #10	Monroe	Edilberto F. Maglasang	Chung H. Khan
	Perry	C. Joseph Campanella	J. Gregg Fozard
	Randolph	O. W. Pflasterer	Allan L. Liefer
	St. Clair (4)	Dennis J. Stanczyk	Charles R. Frazer, Jr.
		Lloyd E. Thompson	Silvana Menendez
		Robert C. Wanless	William A. Simmons
		Ronald G. Welch	Terence G. Klingele
	Washington	Gary A. Goforth	
District #11	DuPage (11)	Peter A. Brusca	Robert D. Dooley
		James P. Campbell	Willard O. Elyea
		Luis E. Cespedes	Thomas W. Stach
		Robert E. Fitzgerald	
		William B. Frymark	
		Morgan M. Meyer	
		James C. Mitchiner	
		Joseph R. O'Donnell	
		Erlo Roth	
		Garth D. Smith	
		Vedantham Srinivasan	
District #12	Boone	Jon E. Dennis	Renuka P. Bale
	Carroll	Basilios G. Lambos	Cecil G. Piper
	DeKalb	John W. Ovitz	Dean A. Miller
	Jo Daviess	David R. Smith	James C. Lambros
	Lee	Donald W. Edwards	David Deets
	Ogle	Don E. Hinderliter	Nancy S. Williams
	Stephenson	Frank Descourouez	Samir Basata
	Whiteside	Thomas Vinje	Surjit Hermon
	Winnebago (6)	Robert A. Behmer	Danny L. Copeland
		Robert L. Bertrand	Gareth A. Eberle
		William E. Kobler	Ervin G. Hrasky
		Joseph B. Perez	Alfred R. HuYoung
		Forrest H. Riordan, III	Fredric C. Kullberg
		Jerome S. Weiskopf	John T. Leonard
Hospital Medical Staff Section		*To Be Determined*	*To Be Determined*
Medical Student Section		Lynn M. Malanfant	Jodie K. Rai
Resident Physicians Section		Janis M. Orlowski	Timothy M. Kuzel

Cook County Delegates

Delegates

Aaronson, Donald W.
Ahstrom, James P., Jr.
Andelman, Samuel L.
Angulo, Ismael
Armstrong, Claresa M.

Beck, Charles A.
Beinar, Peter J.
Bellows, Randall T.
Berg, Max
Blankshain, Richard H.
Bonbrest, H. Constance
Brant, Julius
Brill, Norman R.
Briney, Robert R.
Brislen, Andrew J.
Burke, Edward A.

Carroll, Catherine G.
Casey, Gerald M.
Cermak, Miles
Chodash, Howard B.
Ciskoski, Ronald J.
Coleman, John M.
Compall, Theo. C.
Costanzo, Vincent A., Jr.
Cross, Roland R., Jr.

Del Fava, Raymond L.
Diaz, Alfonso
Diffenbaugh, Willis G.
Dobbertien, Mark A.
Dohrmann, George, III

Fischer, Arthur R.
Fish, Wm. D.
Fitzgibbons, James P.
Flanagan, C. Larkin
Frankel, Jerome J.
Frazier, Robert G.
Fredrick, Earl E., Jr.
Friedell, Morris T.
Friedell, Peter E.

Gertz, Geo. J.
Goodman, Harold
Goyal, Arvind K.
Green, Martin W.
Gueyikian, Berj

Harwood, Thomas R.
Havdala, Henri S.
Hinkamp, Jos. F.
Hoban, Eugene T.
Hyde, John S.

Iannucci, Thos. M.
Iwanetz, Jaroslaus T.

John, Thomas
Johnson, M. Anita
Joslyn, A. Everett

Kirschenbaum, M. Barry
Kirschner, Ronald L.
Kniffin, Judith M.

Lagorio, Geo. L.
Lalmalani, Gopal G.
Lanuius, Greg D.
Libman, Robert H.

Alternate Delegates

Aguilera, Hector G.
Al-Aswad, Basel
Alfano, Jos. E.
Araujo, Julius C.

Baldoza, Maximo B.
Bansal, Vinod K.
Barnhart, William D.
Bekerman, Carlos
Beranek, George B.
Bianchin, James T.
Blair, Kenneth M.
Burdick, Allison L.

Casey Donald E.
Chavez, Ariel R.
Christensen, Eldis M.
Crisp, Elmer E., Jr.
Cucco, Ulisse P.

De Leon, Lilia S.
Desser, Richard K.
Di Marco, Eugene R.
Drueck, Charles, III

Eappen, Kudathummuryil
Earles, Lucius C.

Fabian, Sydney
Fagel, Sorrel E.
Fallah, Abraham
Farah, Geo. S.
Forkosh, David S.

Geline, Richard A.
Gianasi, Chas A.
Gnade, Gerard R.
Gogan, Wm. T.

Halstuk, Kevin S.
Hasrajani, M.
Hirschmann, Richard A.
Holt, Linda H.

Ignatoff, Jeffrey M.

Jackson, Robt. F., II
Jensen, Mary Jane S.
Jones, Richard J.
Joshi, Nalinaksha V.

Kalsch, Harry E.
Knaus, John V.

Lemus, Fraterno
Liboon, Rogelio N.
Lubben, Georgia D.
Lucchesi, K. Gregory

McCabe, Mary J.
McHugh, Rosemary E.
Montero, Jose R.
Murphy, Danl. J.
Murphy, Doug M.
Murphy, Jos. L.

Delegates

Lobraico, Rocco V., Jr.
Locker, Brian K.

MacNerland, Robt. H.
Malvar, Thomas C.
Mason, John W.
McDade, Wm.
Mostowfi, Kiumars
Muriel, Hugo H.
Murray, Meredith B.

Nemecek, Raymond W.
Neskodny, Jaroslav F.

O'Donoghue, Michael J.
O'Sullivan, Donal D.
Okner, Henry B.
Oliver, Adriano S., Jr.

Pedroso, Aldo F.
Perlman, Jack M.
Perritt, Richard A.
Pochyly, Donald F.

Quinlan, Donald

Ray, Biswamay
Renga, Dominick S.
Rice, Clair M., Jr.
Roman, Alan M.
Rothstein, David A.
Rubio, Nunilo

Sagerman, Scott D.
Saulys, Augusta Z.
Saulys, Vacys
Schifano, Joseph
Schimel, Samuel
Seed, Randolph W.
Shapiro, Maynard I.
Short, Marshall H.
Simon, Arnold
Sinaiko, Edwin S.
Smallwood, John T.
Solon, Earl N.
Sprang, M. Leroy
Staley, Warren H.
Suckow, Earl E.
Sugar, Sam J.
Sulo, Robert M.

Tansey, William J.
Tencer, Thomas
Thampy, Kishore J.
Thompson, James R.
Treister, Michael R.
Turow, David D.

Vanecko, Robt. M.
Vega, Jesus G.
Velarde, Hugo R.

Walkowiak, Lydia
Wehrmacher, Wm. H.
Wharton, R.
Whitney, Jack M.
Williams, Jack

Zurita, Victor M.

Alternate Delegates

Nikurs, Lydia

O'Brien, James P.
O'Keefe, Paul
Ostrowski, Terry L.

Palmer, Arthur S.
Palutsis, Philip S.
Panayotou, Irene
Pardo, Yrech
Perkins, Camille E.
Petty, David T.
Pruc, Jeremias N.
Pucci, Rita O.

Raj, H.N. Sundar
Richardson, James M.
Rodrigues, Roger L.
Rodriguez, Alberto E.
Rosenow, Mary K.
Rowley, Nora E.
Rudinger, Ann N.

Salomon, Luis S.
Saltiel, Isaac
Sassetti, Richard J.
Schall, Saml. M.
Scheribel, Karl W.
Senno, Aref
Sevilla, Paulino Z.
Sherrick, Jos. C.
Shima, Arthur T.
Shima, Mark A.
Shobris, Martin
Silverstein, Gerald
Singa, Madhaviah R.
Smith, Sharon C.
Souman, Mouhannad
Stephens, Natalie
Stevenson, George F.
Strohl, Lee H.
Study, Robt. S.
Supple, Peggy A.
Sutoris, Edward D.
Swislow, Mark F.

Troyer, Wm. G.

Vaziri, Ira J.

Wallk, Silas
Weiss, John W.
Welsh, Brady T.
Wigder, Herbert N.
Wojcik, Edward A.

Yalavarthi, Ramaraja B.

Zelinger, Allan B.

Agenda
1987 House of Delegates

Lawrence L. Hirsch, M.D., Speaker/Robert Reardon, M.D., Vice-Speaker

First Session

9:30 a.m. ——— Friday, April 10, 1987 ——— Westin O'Hare Hotel
Grand Ballroom

1. Call to order
   Lawrence L. Hirsch, Speaker
2. Invocation
3. Report of Credentials Committee
4. Report of Committee on Rules and Order of Business
5. Approval of minutes of previous meeting
6. Memorial service for members deceased since April, 1986, conducted by Harold L. Jensen, Secretary-Treasurer
7. Introduction of special guests
8. Remarks of special guests
9. Remarks from ancillary groups
   Patricia Spadoni, President, Illinois State Medical Society Auxiliary
   Mary Lu Ostrowski, President, Illinois Society, American Association of Medical Assistants
10. Educational Awards:
    Certificates of appreciation to continuing medical education examiners
    Presentation of AMA-ERF check to Illinois medical schools
    Hamilton Teaching Award
11. IMPAC report
    George T. Wilkins, Jr., Chairman
12. Introduction of AMA Delegates and Alternate Delegates
    Robert C. Hamilton, Chairman
13. Report of Chairman, Board of Trustees, Alfred J. Kiessel
    Unfinished business A-H
14. Remarks of Speaker
15. Resolutions and supplementary reports
16. New business and announcements
17. Recess until 9:30 a.m., Saturday, April 11, 1987
    Delegates' Buffet—11:30 a.m.-1:30 p.m.
    Reference Committees—1:30 p.m.

Second Session

9:30 a.m. ——— Saturday, April 11, 1987 ——— Westin O'Hare Hotel
Grand Ballroom

1. Call to order by the Speaker
2. Report of Credentials Committee
3. Introduction of special guests
4. Public Service Awards
5. President's address
   Jere E. Freidheim
6. Reports of reference committees
   Amendments to Constitution & Bylaws and Organizational Affairs
   Committee A-Medical Services & Facilities
   Committee B-Medical Economics
   Committee C-Education & Scientific Affairs
   Committee D-Public Relations and Miscellaneous Business
7. New business and announcements
8. Recess until 9:00 a.m., Sunday, April 12, 1987

Third Session

9:00 a.m. ——— Sunday, April 12, 1987 ——— Westin O'Hare Hotel
Grand Ballroom

1. Call to Order by the Speaker
2. Report of Credentials Committee
3. Induction of Allan L. Goslin, President-Elect, into office of President by Jere E. Freidheim
4. Address of President Goslin
5. Announcements and introduction of guests
6. Reports of Reference Committees
7. Elections
   Report of Nominating Committee
   a. President-Elect (Cook County)
   b. 1st Vice-President (Downstate)
   c. 2nd Vice-President (Cook County)
   d. Secretary-Treasurer
   e. Speaker of the House (Downstate)
   f. Vice-Speaker of the House (Cook County)
   g. Trustee terms expiring

District	*Terms Expiring*
First District	David B. Littman
Third District	Alfred J. Clementi
	Joan E. Cummings
	Arthur R. Peterson
	Cyril C. Wiggishoff
Sixth District	George T. Wilkins, Jr.
Ninth District	Warren D. Tuttle
Tenth District	Thomas P. Meirink

   h. Delegates to AMA to take office Jan. 1, 1988 and serve until Dec. 31, 1989

   Terms expiring

   Alfred J. Clementi, Arlington Heights
   Jere E. Freidheim, Chicago
   Allan L. Goslin, Streator
   Robert C. Hamilton, Chicago
   Harold L. Jensen, Chicago
   Morgan M. Meyer, Lombard
   Harry A. Springer, Evanston
   Arthur R. Traugott, Urbana
   Ronald G. Welch, Belleville

   Cook County Delegate to serve immediately and until Dec. 31, 1988 as the 20th delegate to the AMA (nominated by Cook County caucus)

   i. Alternate delegates to the AMA to take office Jan. 1, 1988 and serve until Dec. 31, 1989

   Terms expiring

   Randall T. Bellows, Chicago
   Albino Bismonte, Gurnee
   Joan E. Cummings, Chicago
   Ulrich Danckers, River Forest
   Earl E. Fredrick, Jr., Chicago
   A. Beaumont Johnson, Elgin
   Carlos B. Lara, Pittsfield
   Robert M. Reardon, Bloomington
   Joseph H. Skom, Chicago
   Warren D. Tuttle, Harrisburg

   Alternate delegate from Downstate to complete unexpired term until Dec. 31, 1988 (nominated by Downstate caucus)

   Alternate delegate from Downstate to serve until Dec. 31, 1988 as the 20th Alternate Delegate to the AMA (nominated by Downstate caucus)

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   j. Judicial Panel member to take office April 12, 1987 and serve until April, 1992 (nominated by ISMS President)

   k. Rules & Order of Business Committee to take office April, 1987 and serve until April, 1988
   (Five (5) delegates nominated by the Speaker and Vice-Speaker of the House)

8. Fixing of per capita dues for 1988
9. Selection of meeting place and time for next meeting
10. Unfinished business
11. New business
12. Adjournment, *Sine Die*

ISMS Delegation to the AMA

Delegation Chairman: Robert C. Hamilton, M.D./Secretary: George T. Wilkins, Jr., M.D.

Delegates

To serve from Jan. 1, 1986 to Dec. 31, 1987

(Elected April 27, 1985)

Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Allan L. Goslin, Streator
Robert C. Hamilton, Chicago
Harold L. Jensen, Flossmoor
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana
Ronald G. Welch, Belleville*

To serve from Jan. 1, 1987 to Dec. 31, 1988

(Elected April 5, 1986)

James H. Andersen, Oak Brook
Audley F. Connor, Jr., Chicago
Lawrence L. Hirsch, Northbrook
Joseph R. O'Donnell, Glen Ellyn
Pedro A. Poma, Melrose Park
Richard Quinones, Chicago
P. John Seward, Rockford
Robert M. Vanecko, Chicago
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

Alternates

To serve from Jan. 1, 1986 to Dec. 31, 1987

(Elected April 27, 1985)

Randall T. Bellows, Chicago
Albino Bismonte, Gurnee
Joan E. Cummings, Chicago
Ulrich Danckers, River Forest
Earl E. Fredrick, Jr., Chicago
A. Beaumont Johnson, Elgin
Carlos B. Lara, Pittsfield
Robert M. Reardon, Bloomington*
Joseph H. Skom, Chicago
Warren D. Tuttle, Harrisburg

To serve from Jan. 1, 1987 to Dec. 31, 1988

(Elected April 5, 1986)

Juanito S. Bartolome, Jr., Chicago
H. Constance Bonbrest, Chicago
Manuel O. Guerrero, Moline
Henrietta Herbolsheimer, Chicago
Alfred J. Kiessel, Decatur
William J. Marshall, Chicago
Joseph B. Perez, Rockford
Edie E. Zusman, Chicago

**Elected April 5, 1986 to complete unexpired term to Dec. 31, 1987*

Honorary Members

Frank J. Jirka, Jr., Barrington Hills

John J. Ring, Mundelein

Committees of the House of Delegates

Committee on Rules and Order of Business

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (30 days prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

Committee on Credentials

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform other such duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

Tellers and Sergeants At Arms

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

Reference Committee on Amendments to Constitution and Bylaws and Organizational Affairs

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws, as well as matters relating to officers, trustees, administration, finances and budgets.

Reference Committee A

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical services and facilities, including those such as governmental controls, litigation and hospital activities.

Reference Committee B

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical economics, including such things as third party payors, prepaid systems, and other fees and payment concerns.

Reference Committee C

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education and scientific affairs, including concerns of education and manpower, public health and scientific matters.

Reference Committee D

This committee shall consider and submit its recommendations to the House of Delegates on reports and resolutions relating to public relations, ancillary organizations and miscellaneous subjects, and shall also include any questions which arise pertaining to ethics.

Resolutions
1987 Annual Meeting
ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 9 and, according to provisions of the bylaws, are printed in IMJ by title and subject. Final deadline for resolutions was March 10. At this writing it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

	Subject	Submitted by
Memorials		
	Burtis E. Montgomery	Warren D. Tuttle, District Nine Trustee
	Robert R. Mustell	Pedro A. Poma, Chairman, Cook County Delegation
	Jacob E. Reisch	Michael C. Snyder, District Five Trustee
	George Shropshear	Pedro A. Poma, Chairman, Cook County Delegation
	Peter Talso	Pedro A. Poma, Chairman, Cook County Delegation
Unfinished Business Reports		
Report A	Corporal Punishment in Illinois Schools	Alfred J. Kiessel, for the Board of Trustees
Report B	Policy Statement on Governmentally-Supported Health Facilities	Alfred J. Kiessel, for the Board of Trustees
Report C	Application of Input-Output Economics to Health Care	Alfred J. Kiessel, for the Board of Trustees
Report D	Honesty in Offering an HMO	Alfred J. Kiessel, for the Board of Trustees
Report E	Reduced Dues for Young Physicians	Alfred J. Kiessel, for the Board of Trustees
Report F	Addressing the Health Insurance Needs of the Short-Term Unemployed and Those Persons "Medically Uninsurable"	Alfred J. Kiessel, for the Board of Trustees
Report G	AD Hoc Committee on the Young Physician	Alfred J. Kiessel, for the Board of Trustees
Report H	Medical Staff Bylaws for Outpatient Surgical Centers	Alfred J. Kiessel, for the Board of Trustees

Resolutions

1 (A-87)	Physicians Liens	Pedro A. Poma, Chairman, Cook County Delegation
2 (A-87)	Medicare Changes	Erlo Roth, Delegate
3 (A-87)	Indemnification	Alfred J. Kiessel, for the Board of Trustees
4 (A-87)	ISMS Policy Titled, "Medical Testimony, Expert Witnesses"	Alfred J. Kiessel, for the Board of Trustees
5 (A-87)	Medical Control in Pre-Hospital Care	Alfred J. Kiessel, for the Board of Trustees
6 (A-87)	ISMS Policy Statement Titled "Mental Health"	Alfred J. Kiessel, for the Board of Trustees
7 (A-87)	ISMS Policy Statement Titled "Immunity"	Alfred J. Kiessel, for the Board of Trustees
8 (A-87)	Dual Standard of Care	Alfred J. Kiessel, for the Board of Trustees
9 (A-87)	ISMS Policy Statement Titled "Emergency Medical Care, Provision of"	Alfred J. Kiessel, for the Board of Trustees
10 (A-87)	ISMS Policy Statement Titled "Reimbursement"	Alfred J. Kiessel, for the Board of Trustees
11 (A-87)	ISMS Policy Statement Titled "Direct Billing"	Alfred J. Kiessel, for the Board of Trustees
12 (A-87)	Director of Public Health	Alfred J. Kiessel, for the Board of Trustees
13 (A-87)	Amendment to Chapter VII, Section I and Chapter IX, Section 8A of the ISMS Bylaws	Alfred J. Kiessel, for the Board of Trustees
14 (A-87)	IFMC Bankruptcy	Alfred J. Kiessel, for the Board of Trustees
15 (A-87)	ISMS Policy Statement Titled "Death With Dignity"	Alfred J. Kiessel, for the Board of Trustees
16 (A-87)	ISMS Policy Statement Titled "Confidentiality"	Alfred J. Kiessel, for the Board of Trustees
17 (A-87)	Withdrawing or Withholding Life-Prolonging Treatment	Alfred J. Kiessel, for the Board of Trustees
18 (A-87)	Channeling	Alfred J. Kiessel, for the Board of Trustees
19 (A-87)	Confidentiality and Utilization Review	Pedro A. Poma, Chairman, Cook County Delegation
20 (A-87)	Physicians who Render Second Opinions	Pedro A. Poma, Chairman, Cook County Delegation
21 (A-87)	Policy Statement on "Eyes"	Alfred J. Kiessel, for the Board of Trustees
22 (A-87)	Policy Statement on "Veterans Administration"	Alfred J. Kiessel, for the Board of Trustees
23 (A-87)	Policy Statement on "Examinations"	Alfred J. Kiessel, for the Board of Trustees

ISMS Annual Meeting

Program Summary By Days

WEDNESDAY, APRIL 8, 1987

2:00 p.m.	ISMIE Executive Committee Meeting
4:00 p.m.	Annual ISMIE Membership Meeting
5:00 p.m.	ISMIE Board of Governors Meeting

THURSDAY, APRIL 9, 1987

9:00 a.m.	ISMS Board of Trustees Meeting

FRIDAY, APRIL 10, 1987

7:30 a.m.	ISMS Board of Trustees Meeting
7:30 a.m.	Rules and Order of Business Meeting
8:00 a.m.	Registration
8:00 a.m.	Districts 1, 2, 4, 5, 6, 7, 8, 9, 10, 11 & 12 Caucus
8:00 a.m.	CMS Caucus
8:30 a.m.	Meeting of Reference Committee Members
8:30 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:15 a.m.	IMPAC Annual Meeting
11:30 a.m.	District Meetings
11:30 a.m.-1:30 p.m.	Delegates' Buffet
1:30 p.m.	Reference Committees
7:00 p.m.	President's Night

SATURDAY, APRIL 11, 1987

7:30 a.m.	Public Affairs Breakfast ISMS/ISMSA Benefit Raffle
8:00 a.m.	Registration
8:30 a.m.	CMS Caucus
8:30 a.m.	Districts 1, 2, 4, 5, 6, 7, 8, 9, 10, 11 & 12 Caucus
9:00 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
10:00 a.m.	Medical Student Section Meeting
Noon	Fifty Year Club Luncheon
1:00 p.m.	CMS Caucus (if necessary)
1:30 p.m.	Credentials Committee
2:00 p.m.	House of Delegates
3:30 p.m.	Re-writing the Medical Practice Act Presentation
3:30 p.m.	CME Site Surveyors Workshop
4:45 p.m.	District 1, 2, 4, 5, 6, 7, 8, 9, 10, 11 & 12 Caucus
6:30 p.m.	IMPAC Sustainer Reception

SUNDAY, APRIL 12, 1987

7:30 a.m.	ISMS Board of Trustees Meeting
8:00 a.m.	Registration
8:30 a.m.	Credentials Committee
9:00 a.m.	House of Delegates
	Board of Trustees Reorganization Meeting Immediately Following House Adjournment.

Notification of Annual IMPAC Meeting

The 1987 Annual Meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Friday, April 10, 1987, *immediately following the adjournment of the ISMS House of Delegates.*

11:15 a.m.

Westin O'Hare Hotel

Rosemont, Illinois

All members of IMPAC are invited and encouraged to attend.

The 1987 IMPAC Nominating Committee has met and nominated the following physicians for membership on the IMPAC Council:

James H. Andersen, Oak Brook
Alfred J. Clementi, Arlington Heights
Louis Dondanville, Moline
Edwin Falloon, Palos Heights
Don Hinderliter, Rochelle
Raymond E. Hoffmann, Rockford (to fill term expiring in 1988 of James Laidlaw, who resigned)
John Ovitz, Sycamore
Albert Ray, Jr., Joliet
Biswamay Ray, Chicago
Arthur R. Traugott, Urbana
Jerome Weiskopf, Rockford

YOU'RE INVITED



Breakfast Speaker:
Alfred G. Ronan (D-Chicago)
Illinois House of Representatives

To a complimentary Public Affairs Breakfast Saturday, April 11, 1987, 7:30 a.m. Westin O'Hare Hotel Rosemont, Illinois

Tickets for this breakfast will be available at convention registration during the ISMS Annual Meeting on a first come, first served basis.

For further information, please contact the Governmental Affairs Division at ISMS offices, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. Telephone (312) 782-1654 or (800) 782-ISMS.

The ISMS/ISMSA Benefit Raffle will be held immediately following the Public Affairs breakfast.

ISMS Auxiliary
59th Annual Meeting
Westin O'Hare Hotel

WEDNESDAY, APRIL 8

1:00-6:00 p.m.	House of Delegates Registration
2:00 p.m.	Pre-Convention Board of Directors Meeting
6:00 p.m.	Board of Directors Dinner (Guests & Delegates Welcome)
8:00-10:00 p.m.	Auxiliary Hospitality (Guests & Delegates Welcome)

THURSDAY, APRIL 9

7:30 a.m.	House of Delegates Registration Complimentary Continental Breakfast Reference Committee Personnel Meeting
9:00 a.m.	First House of Delegates Session Call to Order and Greetings Opening Ceremonies Reading of Rules Appointment of Reading and Reference Committees Treasurer's Report Reading of Budget President's Report to House of Delegates
9:45 a.m.	Keynote Speaker: Mrs. Betty Szewzcyk (Edward), President-Elect of the American Medical Association Auxiliary and Past President of the ISMS Auxiliary
10:15 a.m.	Nominating Committee Report Nominations and Election Instructions
10:45 a.m.	Introduction of Resolutions
11:00 a.m.	Reference Committee Hearings Organizational Affairs Health Concerns
Noon	Awards and Recognition Luncheon (Guests and Delegates Welcome) Memorial Service Awards Presentations
2:15 p.m.	House of Delegates Session continued Legislative Update County Presidents' Reports
6:00 p.m.	Pin and Gavel Dinner (Past Presidents Only)
8:00-10:00 p.m.	Auxiliary Hospitality (Guests and Delegates Welcome)

FRIDAY, APRIL 10

7:30 a.m.	House of Delegates Registration
	Reference Committee Reports Available
	Complimentary Continental Breakfast
8:00 a.m.	Mini-Workshops
9:00 a.m.	Second House of Delegates Session Elections County Reports continued
10:15 a.m.	Reference Committee Reports Budget Approval
	Election Results
10:30 a.m.	President-Elect Preview of 1987-1988 Auxiliary Year
11:30 a.m.	President's and Installation Luncheon and Fashion Show (Guests and Delegates Welcome)
	Installation of 1987-1988 ISMSA Officers Fashion Show Annual Meeting Adjournment
3:15 p.m.	Board of Directors Photograph
3:30 p.m.	Post-Convention Board of Directors Meeting
7:00 p.m.	ISMS President's Night—Honoring Jere E. Freidheim, M.D.

SATURDAY, APRIL 11

7:30 a.m.	ISMS Public Affairs Breakfast
	ISMS/ISMSA Benefit Raffle for the ISMS Medical Student Loan Fund.

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (October). Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

Name: _____ City: _____ Zip: _____

Address: _____

Telephone: ( ) _____

County Medical Society: _____

Medical specialty and type of practice: _____

Committee in which interested: _____

Expertise for this committee: _____

Send to: Chairman, Board of Trustees, Illinois State Medical Society
Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

Notice of Annual Meeting

of Members

of the

Illinois State Medical

Inter-Insurance Exchange

Wednesday, April 8, 1987

4:00 p.m.

Westin O'Hare Hotel

6100 River Road

Rosemont, Illinois

ISMS Delegates and Alternate Delegates

STOP

At the **Illinois Outreach Desk** near the registration area, for information about members and non-members in your county.

Open all day Friday and Saturday, staff members are anxious to help you recruit **new members** to organized medicine.

A grand prize will be presented to the person who recruits the most **new members**.

ILLINOIS STATE MEDICAL SOCIETY
ILLINOIS STATE MEDICAL SOCIETY AUXILIARY

Fourth Annual Benefit Raffle

Grand Prize: Personal Computer and Printer

2nd Prize: Drake Hotel Weekend, Chicago

3rd Prize: Ritz-Carlton Hotel Weekend, Chicago

4th Prize: Dinner for Two at L'Escargot on Michigan Avenue, Chicago

5th Prize: "Day of Beauty" at the Beauty Salon of Saks Fifth Avenue, Chicago

6th Prize: Gift Certificate for Mark Shale, Chicago

7th Prize: A Personalized Facial from Rodica Skin Care Products, Inc., Chicago

8th Prize: Gift Certificate for a Haircut, Styling and Makeup Lesson from Paul Glick, Chicago

Other prizes to be announced

Drawing Held Saturday, April 11, 1987
Immediately following the Public Affairs Breakfast
at ISMS Annual Meeting

Ticket books have been mailed to all
ISMS/ISMSA members

$25.00 per 5-ticket book

Contributions to the ISMS Educational and Scientific Foundation are normally tax deductible to the extent allowed by law.

Thirty-First Annual Convention

By Robin Bluestein, CMA-C/Chicago

The 31st Annual Meeting of the Illinois Society of Medical Assistants will be hosted by the McLean County Chapter. The theme for this year's meeting is "Wonderful World of Medical Assisting." The convention will be held at the Sheraton Inn, 8 Traders Circle in Normal, Illinois beginning at 5:00 p.m. on Thursday, April 23 and adjourning after a council meeting on Sunday, April 26.

The official convention opening begins at 8:00 p.m. on Thursday, with a ribbon cutting ceremony followed by a welcome party and a campaign display where members can meet the candidates.

The 1987 House of Delegates will convene at 9:00 a.m. on Friday, April 24. A number of issues will be brought before the House for discussion and voting. Members will have an opportunity to express their opinions and comments at reference committee meetings during the mid-morning break. Those eligible will vote after those meetings have concluded. The House will reconvene at 2:30 p.m. and adjourn at approximately 5:00 p.m.

The President's Dinner will begin at 7:30 p.m., with Mary Lu Ostrowski, CMA, presiding.

Educational programs will be offered Saturday and will feature the following:

- "Legal Rights in the Wonderful World of Medical Assisting," *Donald Balasa,* AAMA Attorney
- "Infertility in the 80s," *George O'Neil, Jr., M.D., S.C.,* OB/GYN, Normal, Illinois
- "Plastic Surgery—Necessary and Just to be Beautiful," *Otis Allen, M.D., S.C.,* Plastic Surgeon, Bloomington, Illinois
- "Update on Skin Care, Skin Cancer, and Skin Sense," *Kent Taulbee, M.D., S.C.,* Dermatologist, Bloomington, Illinois
- "Proper Ways of Collecting in the Medical Office," *Jack Sprinker,* Financial Collection Agency
- "Health Promotions in the 80s and What the Surgeon General Didn't Tell You," *Luke Buschard, M.D.,* Illinois President of DOC (Doc's Ought to Care)

The annual awards luncheon will also be held on Saturday.

The inaugural banquet for the incoming and outgoing ISMA officers will be held Saturday evening with cocktails at 6:30 p.m. and dinner at 7:30 p.m.

The new executive committee will first meet Sunday at 8:00 a.m. At 9:00 a.m., the farewell brunch will be presented by the 1988 convention committee, Northwest Cook County Chapter. Finally, the convention will close with a council meeting at 11:00 a.m.

Throughout the four-day convention, exhibits, arts and crafts, history books, and chapter publications will be on display.

We would also like to express appreciation to the McLean Chapter for the time and effort devoted to hosting the 1987 Annual Meeting, and to wish them every success.

Information regarding the Illinois Society and/or medical assisting can be obtained from Mary Lu Ostrowski, CMA, president, Illinois Society, 1704 E. Jackson Street, Bloomington 61701; Robin Bluestein, CMA-C, co-chairman, public relations committee, 2247 West Estes, #2, Chicago 60645, or Catherine M. Hill, CMA, co-chairman, public relations committee, 900 South Plum Grove Road, Palatine 60067. ◂

Abstracts of Action

Continued from page 130

- Approved changing the name of the ISMS Committee on Laboratory Services to the ISMS Blood Banking and Laboratory Services Committee, in order to make the committee more identifiable to outside groups interested in the ISMS' position on blood-related issues.
- Agreed that medical school affiliation be preferred, but not required, for members of the *Illinois Medical Journal* Editorial Board.
- Approved pursuing a consolidation of the Illinois State Medical Society-Sponsored Membership Insurance Programs with the Chicago Medical Society Trust.
- Agreed not to be specifically identified with any one regional physician placement activity until the Council on Education and Manpower has reviewed a state-wide perspective on physician placement issues.
- Referred back to the Council on Medical Services a request for development of a liaison committee composed of representatives of ISMS, the Illinois Association of Athletic Trainers and the Illinois High School Association to provide a forum to discuss medical issues related to high school athletics.
- Agreed to support proposed revisions in the Illinois Blood Banking Act.
- Agreed to notify the Illinois Department of Public Health that a patient in an intermediate care facility for the mentally ill should be seen by a psychiatrist at least every six months.
- Agreed to support the controlled substance rescheduling of Dronabinol from Schedule I to Schedule II.
- Authorized the Committee for the Impaired Physician to conduct a survey of medical schools related to substance abuse curriculum and student support activities.
- Authorized the Planning and Priorities Committee to proceed with its review of ISMS Goals and Objectives for the purpose of recommending revisions, particularly in the areas of communications/public relations, membership and education.
- Asked the Council on Economics to study the potential need for offering assistance to displaced physicians when hospital medical staffs are closed to certain specialties or the hospital ceases operation.
- Approved that Medical Student Section school chapters may work with the Doctors Ought to Care (DOC) organization for the purpose of coordinating local anti-smoking activities.

RESOLUTIONS/UNFINISHED BUSINESS REPORTS

On recommendation, the Board approved the following:

Resolutions for 1987 House of Delegates

- Removal of all references to the Illinois Foundation for Medical Care from the ISMS Bylaws and Policy Manual.
- Encourage ISMIE to conduct a study on how the concept of channeling might be appropriately applied to the Illinois professional liability market.
- Amend policy statement titled, "Confidentiality."
- Delete policy statement titled, "Death with Dignity."
- Policy statement titled, "Withholding or Withdrawing Life-Sustaining Treatment."
- Development of Memorial Resolutions for Drs. Jacob E. Reisch, Honorary Past President of ISMS, and Burtis E. Montgomery, who served as President of ISMS and as an AMA Trustee.

Unfinished Business Reports

- Approved Unfinished Business Report on Resolution 30 (A-86), titled "Young Physicians Study."
- Agreed to assign Unfinished Reports to Reference Committees for their review and recommendation.

PROGRAMS

The Board:

- Agreed to cooperate with Northwestern University Medical School's Perinatal Center for Chemical Dependency in the publicizing of conferences for physician education relating to the effects of substance abuse in pregnancy and the newborn.
- Approved a proposed 1987 pilot program for seminars on the business aspects of medical practice.

NOMINATIONS, APPOINTMENTS, AWARDS

Various nominations, appointments and awards were approved by the Board, as follows:

- Nominated Joseph Giordano, D.O., LaGrange, to serve on the IDPH Diabetes Advisory Council.
- Ratified nomination of James W. Girardy, M.D., Rockford, to serve on the State Emergency Medical Services Council.
- Nominated Sam Gaines, M.D., Springfield, to serve on the DASA Advisory Council on Alcoholism and Substance Abuse.
- Named Dr. Richard J. Sassetti, Chicago, to the ISMS Blood Banking and Laboratory Services Committee.
- Approved Drs. Richard H. Dominguez, Glen Ellyn; Roger Hendricks, Herrin; Russell Oyer, Chenoa; James C. Reid, Greenfield; and Howard J. Sweeney, Evanston, for the 1986-87 Outstanding Team Physician Awards.
- Approved Earl M. Stockdale, M.D., Rock Island, and Representative Lee Daniels, House Republican Leader, to receive 1987 ISMS Public Service Awards.
- Agreed to recognize Dr. Joseph DiCara, Chicago, with a Certificate of Merit and Appreciation for his efforts with the Cabrini Green Youth Program.

OTHER MATTERS

SOBRA

The Society's Third Party Payment Processes Committee met with representatives of Blue Cross/Blue Shield, the Medicare Part B carrier for Illinois, to discuss the implementation of the SOBRA provisions that impact

Part B Medicare. The AMA was successful in obtaining a temporary restraining order which postponed the implementation of SOBRA's Medicare provisions to January 20, 1987. The injunction also extended the time for physicians to either elect a new participation status or continue their current status as participating or non-participating physicians in the Part B Medicare programs. Various other provisions called "beneficiary incentives" are being discussed in order to obtain clarification. HCFA has not yet supplied specifics of many elements of the Reconciliation Act. Diagnostic clinical laboratory services performed in a physician's office will be reimbursed at the assigned rate; no co-payment or deductible billing will be permitted.

Medical Student Loan Fund
The Task Force on Financial Aid to Medical Students in conjunction with the ISMS Auxiliary is once again sponsoring a benefit raffle at the 1987 Annual Meeting to help raise funds for the ISMS medical student loan fund. The Society's student loan program has already offered $350,000 in loans to Illinois medical students.

Peer Review Organization Issues
The Health Care Financing Administration (HCFA) has developed regulations that would require PROs to notify beneficiaries of any potential payment denials when a case subject to review is denied for allegations of gross and flagrant patient care. The Crescent Counties Foundation for Medical Care (CCFMC), the Peer Review Organization (PRO) for Illinois, shares ISMS concerns about the potential increase in professional liability actions based on potentially unfounded allegations without allowing the affected physician to complete all avenues of appeal.

Additionally, under the previous Budget Reconciliation Act, (COBRA), PROs are required to implement a second surgical opinion program during 1987. There are several issues which require clarification from HCFA prior to this program being implemented, such as criteria and guidelines to be used by PROs. CCFMC will inform ISMS of the targeted procedures and effective implementation date once they are finalized.

Further, beginning April, 1987, PROs will be required to conduct review of HMO services. HCFA has awarded HMO review contracts to PROs in some states. However, Illinois will be subject to a competitive bidding process for HMO review. CCFMC anticipates the release of an RFP during the month of January with March targeted for actual negotiation and awarding of contracts. HCFA appears to be committed to implementing HMO review April 1, 1987.

Re-Write of the Medical Practice Act
The Ad Hoc Committee on the Re-Write of the Medical Practice Act continues to review drafts of the Act and to discuss its concerns with the Department of Registration and Education. Committee representatives met with the Director of R & E and discussed the following issues: (1) That ISMS believes the amount and time frame for physicians' licensure fees will be mandated by statute, and that ISMS would oppose any effort to place this authority subject to departmental rule; (2) Suggested that perhaps the re-write of the Act could contain language stating that all applicants for full licensure in Illinois be required to serve a three year residency program regardless of the medical school attended; and (3) That R & E must justify the need for any proposed increase in physician licensure fees including an accounting of current expenditures prior to its consideration by ISMS.

Health Care Improvement Act
President Reagan has signed S 1744 into law. Initial legal counsel analysis, based upon portions of the legislation, indicates that individuals engaging in professional review activities in good faith are granted immunity from liability under federal law. There is an exception to this immunity for certain Clayton Act (antitrust) actions. Legal counsel will develop an analysis of the Act, pending publication of Rules and Regulations.

Comprehensive Health Insurance Plan (S 1699)
The recent passage of the Comprehensive Health Insurance Plan (CHIP) will allow individuals who have been refused insurance coverage for health reasons, who have been excluded based upon a pre-existing condition, or who have been offered health insurance only at a very high premium, to purchase health insurance. The CHIP will begin operation on January 1, 1988. The CHIP will be operated by an eleven-member board and funded by premiums paid by insureds (to be equal to 135% of the rate which a standard risk would be charged) and General Revenue funds. Under the CHIP many people who previously could not obtain health insurance will be able to obtain comprehensive insurance. This will be reported further as rules and regulations are developed and implementation has begun.

Informational Reports
Informational reports were presented by ISMIS, ISMIE, Resident Physicians Section, Auxiliary, IMPAC, Trustees and AMA Delegation.

LEGAL COUNSEL MATTERS

The Illinois Supreme Court has granted a Motion to hear an appeal in a suit which challenged the constitutionality of the certificate of merit requirement under the 1985 Medical Malpractice Reform Act. ISMS will enter this case with an *amicus curiae,* in conjunction with ISMIE.

Other issues currently being followed by legal counsel are lawsuits brought by the Department of Registration & Education against naprapaths and acupuncturists. The allegation is that there has been an unauthorized practice of medicine. Counsel also is reviewing the role which ISMS might play in an observer status regarding the Alliance of State Physician Networks, a group proposing to engage in review of Governmental contracts for CHAMPUS.

NEXT MEETING

The next Board of Trustees meeting was set for April 9, 1987, at the Westin O'Hare Hotel, Rosemont. ◀

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

APRIL

Immunization

First Annual Immunization Conference
For: Physicians and other health care professionals. Conference, April 1-2, Sheraton Inn, Springfield, IL. **Sponsors:** Illinois Department of Public Health and Illinois Public Health Association, 428 W. Jefferson, Springfield, IL 62702. **Fee:** $35 for IPHA members and $70 for nonmembers. **Reg. Limit:** None. **Credit:** None. **Contact:** Gina Selmo. **Phone:** (217) 522-5687.

Pathology

T-Cell Lymphomas
For: Pathologists. Lecture, April 13, Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Orthopedic Surgery

Surgery of the Spine: State of the Art
For: Orthopedic and neurological surgeons. Symposium, April 29-May 2, St. Louis, MO. **Sponsors:** St. Louis University School of Medicine, CME, 1402 Grand Blvd., St. Louis, MO 63104 and Cardinal Glennon Childrens Hospital. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 24 hours. **Contact:** Anita Herbst. **Phone:** (314) 577-8167.

Ophthalmology

11th Annual Ophthalmology Current Concepts Seminar '87
For: Ophthalmologists and ophthalmologic nurses. Conference, April 2-4, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, and Department of Ophthalmology, School of Medicine, University of Wisconsin. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 18 hours and University of Wisconsin CEUs: 18 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Cancer

Lymphoma and Biological Response Modifiers
For: Physicians. Symposium, April 10, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $20. **Reg. Limit:** 200. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; and ADA: 6 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

OB-GYN

High-Risk Obstetrics
For: Obstetricians, gynecologists, and family physicians. Lecture, April 2-4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $310. **Reg. Limit:** 90. **Credit:** Category 1: 21 hours; AAFP Prescribed: 20 hours; and ACOG: 20 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Specialty Review in Obstetrics and Gynecology
For: Obstetricians and gynecologists. Lecture, April 20-25, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $715. **Reg. Limit:** None. **Credit:** Category 1: 56 hours; ACOG: 54 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

14th Annual Symposium on Obstetrics and Gynecology
For: Physicians. Symposium, April 23-24, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $200. **Reg. Limit:** 200. **Credit:** Category 1: 13.25 hours; AAFP Prescribed: 13.25 hours; ADA: 13.25 hours; and ACOG: 13 cognates. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Emergency Medicine

Advances in Emergency Medicine, 1987
For: Emergency medicine physicians. Lecture, April 20-22, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $370. **Reg. Limit:** 90. **Credit:** Category 1: 25 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Modern Trauma Management
For: Surgeons and emergency medicine physicians. Lecture, April 23-25, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $370. **Reg. Limit:** 90. **Credit:** Category 1: 20 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Surgery

Advances in Surgery, 1987
For: General and specializing surgeons. Lecture, April 27-May 1, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $570. **Reg. Limit:** None. **Credit:** Category 1: 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Cardiac Rehabilitation

Cardiac Rehabilitation Workshop
For: All interested physicians and other health care professionals. Workshop, April 6-10, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, LaCrosse Exercise and Health Program, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP: 35 hours; and 3.5 CEUs from UW-LaCrosse. **Contact:** Philip K. Wilson, Ed.D., University of Wisconsin-LaCrosse. **Phone:** (608) 785-8686.

Cardiology/Internal Medicine/Family Medicine

Primary and Secondary Prevention of Heart Disease: Making the Right Decisions.
For: Physicians and allied health personnel. Symposium, April 29-May 1, Milwaukee, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, and Cardiovascular Disease Center, University of Wisconsin-Milwaukee Clinical Campus, and Mt. Sinai Medical Center, Milwaukee, WI. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 15 hours and University of Wisconsin CEUs: 15 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

May

Health Care

Symposium: The Transformation of the American Health Care System **For:** Interested physicians. Symposium, May 1-2, Mead Inn, Wisconsin Rapids, WI. **Sponsors:** The State Medical Society of Wisconsin and the Riverview Hospital Association, 410 Dewey St., Wisconsin Rapids, WI 54494. **Fee:** $145. **Reg. Limit:** None. **Credit:** Applied for. **Contact:** Riverview Hospital Association. **Phone:** (715) 423-6060, Ext. 410.

Neuroradiology

1987 Neuroradiology Review Course
For: General radiologists, neuroradiologists, neurosurgeons, neurologists, and residents. Course, May 2-3, Oakbrook Marriott Hotel, Oak Brook, IL. **Sponsor:** Loyola University Medical Center, 2160 South First Avenue, Maywood, IL 60153. **Fee:** $170 for physicians and $100 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3237.

Family Practice/Cardiology/Internal Medicine/Pulmonary

48th Annual Theodore Lang May Day Clinic
For: Physicians, residents, students, and nurses. Seminar, May 1-2, Clock Tower Inn, Rockford, IL. **Sponsors:** St. Anthony Medical Center, 5666 East State St., Rockford, IL 61108 and University of Illinois College of Medicine at Rockford and the Rockford Medical Education Foundation Family Practice Residency Program. **Fee:** $125. **Reg. Limit:** 500. **Reg. Deadline:** April 15 (late registration: May 1). **Credit:** Category 1: 9 hours. **Contact:** Betty Noegel. **Phone:** (815) 226-2000, Ext. 5190.

Internal Medicine

Pulmonary Function Evaluation
For: Physicians. Lecture, May 5, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Midwestern Study Conference
For: Primary care physicians. Lectures and workshops, May 20-22, Chicago. **Sponsor:** Chicago College of Osteopathic Medicine, 5200 S. Ellis Avenue, Chicago, IL 60615. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 24 hours. **Contact:** Hope Wheeler. **Phone:** (312) 947-4983.

Hypertension and Quality of Life
For: Physicians. Lecture, May 26, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115 and Pfizer Laboratories. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Pathology

Current Problems in Cervical Neoplasia
For: Pathologists. Lecture, May 11, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Radiology

Mammography
For: Physicians. Lecture, May 12, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Infectious Diseases

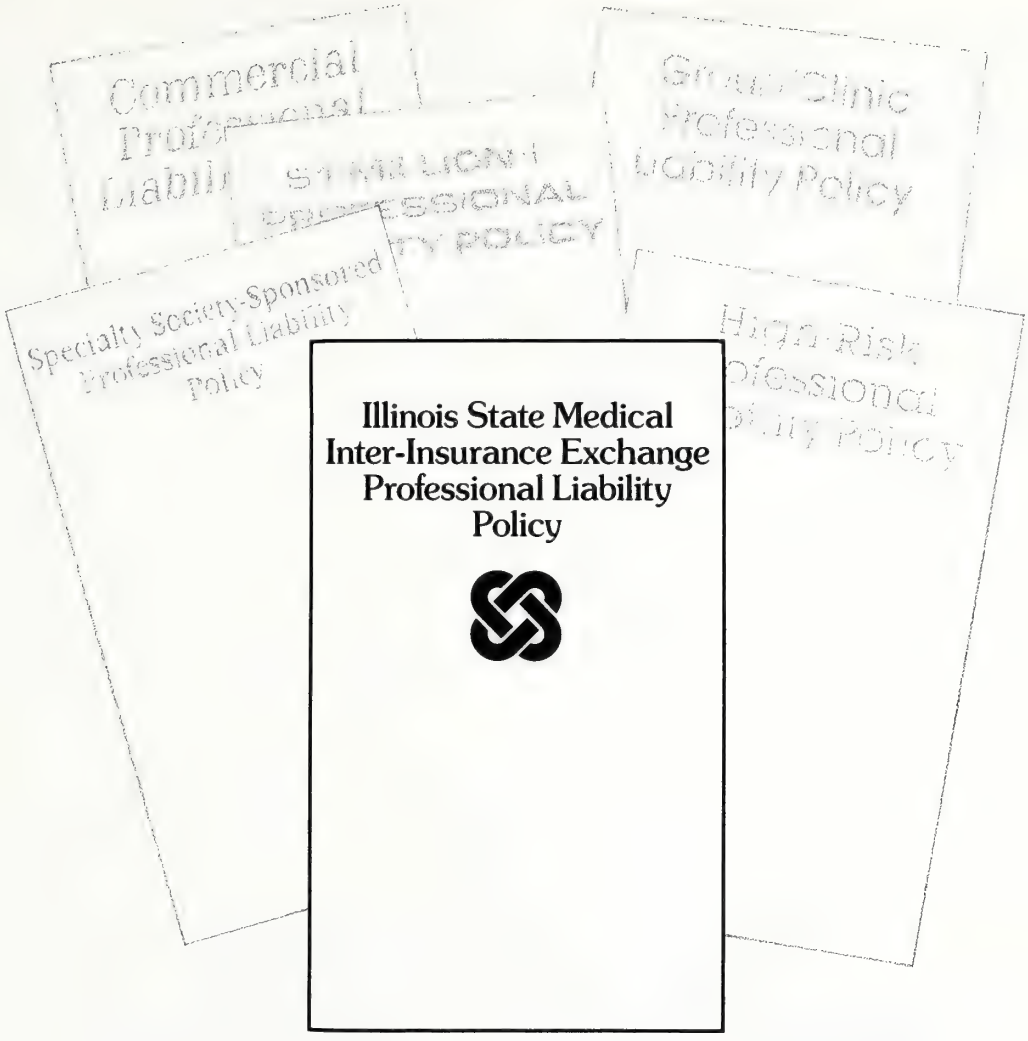
Fever—Undetermined Origin
For: Physicians. Lecture, May 19, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

General Medicine

Update on Diabetes Mellitus
For: Physicians. Lecture/symposium, May 20, McHenry, IL. **Sponsors:** University of Illinois College of Medicine at Rockford and Northern Illinois Medical Center, 4201 Medical Center Drive, McHenry, IL 60050. **Fee:** None. **Reg. Limit:** None. **Reg. Deadline:** April 1. **Credit:** Category 1: 6 hours. **Contact:** Fran Glosson, Northern Illinois Medical Center.

Malpractice

Medical Malpractice and the Doctor/Patient Relationship
For: Physicians. Conference, May 21, Milwaukee, WI. **Sponsors:** Center for the Study of Bioethics, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226 and St. Luke's Hospital, Milwaukee. **Fee:** $100. **Reg. Limit:** None. **Credit:** Category 1: 4.5 hours; CEU: 4.5 hours. **Contact:** Anne Marie Talsky. **Phone:** (414) 257-8692.



A disappearing act?

The number and size of damage claims against physi-
ıns continues to rise. And it's drying up most sources
malpractice insurance for Illinois doctors.
But there's one company that will still be here even if
the others are gone. The Illinois State Medical Inter-
surance Exchange.
The Exchange is a company owned and operated by
policyholders. As such, we put our policyholders
ead of profit.
Unfortunately, the Exchange is not immune from the
vages of the current legal situation. The shrinking
ailability of backup insurance protection is forcing us
offer only claims-made policies after July 1.
But even with claims-made, we intend to make sure
at Exchange policyholders will continue to have the best professional liability protection available. The same aggressive defense of frivolous suits. And programs to help you avoid the incidents that can lead to malpractice suits.

The Illinois State Medical Inter-Insurance Exchange. There when you need it.

Illinois State Medical Inter-Insurance Exchange
Twenty North Michigan Avenue
Suite 700
Chicago, Illinois 60602
(312) 782-2749 800-782-ISMS (Toll-Free)

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—to join an established four member group of general internists in Bloomington-Normal, Illinois. Complete office facilities. Midwestern University community with strong economic base. Contact: Judy Buchanan, Administrative Director, The Health Center, 702 North East Street, Bloomington, 61701, (309) 827-5051. (6)

GIBSON CITY:
Opportunities for Family Practice and Internal Medicine either in partnership with a family practitioner or in solo practice. Fully equipped office facility and income support arrangements available. Stable farm community serving 20,000 population within a 20 mile radius. 30 miles north of Champaign-Urbana. Three hour drive south of Chicago. Contact: Terry Thompson, Administrator, Gibson Community Hospital, 1120 North Melvin Street, Gibson City 60936, (217) 784-4251. (4)

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

GRAYVILLE:
On Interstate 64, population 3,000 64,000 medical market area. New completely furnished medical clinic facility. Financial package, twenty minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: Rebecca S. Alcorn, 320 S. Second Street, Grayville, 62844 or call (618) 375-2171 weekdays and (618) 375-3431 evenings and weekends. (6)

LINCOLN:
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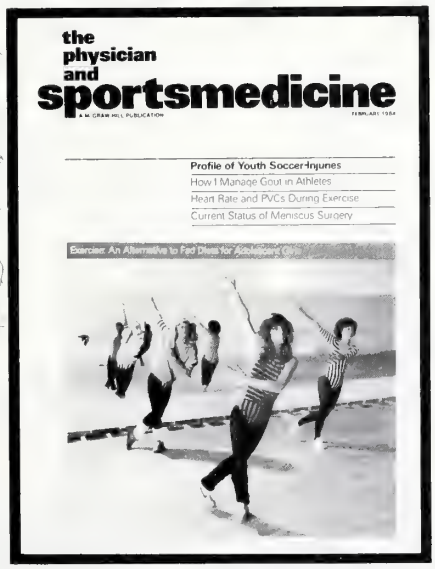
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Viewbox

(Continued from page 128)

Diagnosis: Bezoar

An abscess could have a mottled appearance in the left upper quadrant, but would not cause an intraluminal filling defect in the small bowel. Blood in the stomach could also have a mottled bubbly appearance in the left upper quadrant. It would, however, be extremely rare for it to obstruct the small bowel.

Patient One could have gastric carcinoma with gastric outlet obstruction and retained food. Again, however, it would be extremely rare for a carcinoma to cause a filling defect in the ileum. A gastric bezoar commonly causes a mottled density in the left upper quadrant. Gastric bezoars can fragment, and, not infrequently, lead to small bowel obstruction.

Definition

Bezoars are conglomerates of undigested material or concretions of foreign matter which occur in the gastrointestinal tract, most commonly in the stomach.

Classification

Phytobezoars are composed of undigested vegetable matter rich in cellulose, classically persimmons, but commonly citrus fruit, cabbage and figs. Trichobezoars are composed of hair or other fibers. Bezoars can also be composed of a variety of foreign material such as glue, tar, paraffin, or wood fibers which form indigestible concretions. Medication bezoars, lactobezoars in neonates, and candidal bezoars have been reported.

Formation in Normal Stomach

Bezoars may occur in the normal stomach as a result of the ingestion of hair or other foreign material which can not readily pass through the pylorus. Most common in this setting are trichobezoars, which occur in normal patients or in patients with underlying psychiatric disorders.[1] The only phytobezoar which commonly occurs in the normal stomach is the diospyrobezoar (persimmon bezoar).[1] Diospyrobezoars result when tannin in unripe fruit forms a coagulum in the presence of gastric acid, thereby entrapping the pulp and seeds.[2]

Formation in Postoperative Stomach

There are several conditions which predispose to bezoar formation. The highest incidence of phytobezoar formation is in patients who have undergone partial gastrectomy, particularly with vagotomy.[1,3,4] This surgery results in diminished secretion of hydrochloric acid and pepsin, resulting in decreased peptic and proteolytic activity. In addition, hypoperistalsis results in poor mixing and delayed gastric emptying. Proteins and mucus can become trapped in a matrix of indigestible cellulose, with resulting phytobezoar formation. Vegetable matter rich in cellulose, particularly citrus fruit, is most commonly identified in these bezoars.[5,6] Postgastrectomy patients may also develop bezoars composed of yeast, particularly *Candida albicans*.[7] The reported incidence of postgastrectomy bezoar formation is 5%-12%.[4,8] Bezoars may not become evident for 5-10 years following surgery.[6,9]

Formation in Small Intestine

Occasionally, adhesions, congenital bands, or diverticula with localized regions of stasis may lead to bezoar formation in the small bowel.[10,11]

Systemic Diseases and Bezoars

Several systemic diseases are associated with bezoars, most notably diabetes mellitus.[12] Diabetic autosomal neuropathy causes gastric stasis and may be complicated by phytobezoars. The bezoar may lead to the initial diagnosis in some patients. Hypothyroidism, scleroderma, and myotonic dystrophy are also associated with gastric stasis and bezoar formation.

Medication Bezoars

A variety of medications can predispose to bezoar formation, either through systemic or local effects. Cimetidine therapy has recently been implicated as a cause of gastric bezoars, probably secondary to achlorhydria and hypoperistalsis.[13] Bezoars composed of aluminum hydroxide gel, cholestyramine, and sodium polystyrene sulfonate have been reported.[14] A "giant colonic bezoar" composed entirely of psyllium seed husks has also been reported in a patient receiving bulk laxative therapy for chronic constipation.[15]

Lactobezoars

Lactobezoars can occur in neonates who are fed concentrated formulas composed of lactose, casein and medium chain triglycerides.[16] Delayed gastric emptying in low birth weight infants and dehydration are predisposing factors.

Clinical Findings

The presentation of gastrointestinal bezoars varies widely. Symptoms include vague or intermittent abdominal pain, fullness, early satiety, and nausea and vomiting. Patients with bezoars may be asymptomatic. A history of edentulism and poor mastication may be elicited in some. Bezoars can lead to a variety of complications. In the classic work of Debakey and Ochsner, the most frequent complication was intestinal

obstruction (17%).[1] In several studies of intestinal obstruction, bezoars were responsible in 0.3%-6% of the cases.[17-19] Other complications include acute or intermittent gastric outlet obstruction, gastritis and occasional gastrointestinal bleeding. There have also been case reports of appendicitis, pancreatitis, and intussusception believed to be secondary to bezoars.

Radiology

On plain radiography, bezoars often appear as mottled or bubbly, most commonly in the left upper quadrant. This appearance is not specific and can also be produced by an abscess, blood, or normal gastric contents. Barium examination reveals an intraluminal filling defect in the involved viscus. In the stomach or gastric remnant, the bezoar is generally freely mobile. Barium fills the interstices of the bezoar creating a mottled appearance. Delayed films may show residual barium coating the bezoar. It may be impossible to differentiate food in the stomach from a bezoar on a single study, but on delayed films the stomach will empty food, while a bezoar will persist.

Treatment

Once the diagnosis is established, a variety of treatment regimens is available. Enzymatic dissolution of bezoars has been performed. Endoscopic fragmentation has also met with success. These procedures are not, however, without complications. Digestion and fragmentation of the gastric bezoar may lead to small bowel obstruction.[20] If these procedures fail, or if the patient presents with a small bowel obstruction, surgical intervention is usually necessary. Gastrotomy or enterotomy is performed with direct removal of the bezoar. It is important to remember that multiple bezoars can exist. If a small bowel bezoar is removed through an enterotomy, the stomach should be scrutinized to avoid missing a second bezoar. Bezoars can also recur, particularly in predisposed patients. ◂

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EKG

(Continued from page 120)

Answers: 1. D 2. E

This twelve lead ECG shows a well-functioning AV sequential pacemaker in the DVI mode. The atrial and ventricular pacing spikes are best seen in lead V2. There is left axis deviation of the ventricular paced beats, probably because the ventricular pacing lead is in the right ventricular apex. This pacemaker senses and paces both the atria and the ventricles and is inhibited by spontaneous activity in either chamber. If no events or beats are sensed in either the atria or the ventricles, then the atria will be paced, a programmed AV delay will occur and the ventricles will be paced at the lower rate limit (here, 75 beats per minute). This is called the DVI mode.

In 1974 the pacemaker study group of the Inter-Society Commission on Heart Disease Resources (ICHD) recommended a three position letter code for pacing modes. The first position is the chamber paced, the second is the chamber sensed, and the third position is the pacemaker mode of response. One patient actually had a DDD AV sequential pacemaker. The pacemaker could sense and pace the atria as well as the ventricles, and could be inhibited by spontaneous activity in either chamber. It had many programmable functions, including an upper and a lower heart rate limit and an AV delay. Future letter codes may contain five positions because of the increased complexity and programmability of newer pacemakers.

An understanding of DDD pacemakers requires an examination of pacing intervals rather than just the heart rate. The timing cycles initiated by paced or sensed beats in the atria or ventricles must be studied. It also helps to know the patient's specific pacemaker model since there may be differences among manufacturers.

In this patient, no treatment was needed at this time. At other times, her sinus beats would be sensed and the ventricles would be paced after a programmed AV delay of 0.14 seconds. For more information see MODERN CARDIAC PACING (Barold, S. [ed] Mount Kisco, New York. Futura Publishing Company, 1985.) ◀

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OTOLARYNGOLOGY—Canton, Illinois, 30 miles SW of Peoria. Join 11-physician multispecialty group. Affiliation with 225-bed hospital and trauma center. Diverse practice-referral base exceeds 50,000. Excellent salary and benefits. Phil Kelbe, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; (414) 785-6500.

FAMILY/INTERNAL MEDICINE practice available immediately for sale, contract or partnership in Monmouth, Illinois—population 15,000. Well established, fully equipped. Excellent, friendly family community. Terms negotiable. Reply to Box #2031, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FACULTY—AMBULATORY PEDIATRICS— the department of pediatrics, University of Illinois College of Medicine at Peoria, has a full-time faculty position available March 1, 1987, or after. Teaching, service and

research responsibilities. Board certified/eligible in pediatrics. Training in adolescent medicine desirable. Preference given to active clinical practice brought into University program. Rank and salary commensurate with qualifications and responsibility. The University of Illinois is an affirmative action-equal opportunity employer. Send curriculum vitae and three reference letters to: William H. Albers, M.D., Professor and Chair, Department of Pediatrics, University of Illinois College of Medicine at Peoria, Box 1649, Peoria, IL 61656. Phone: (309) 655-2570.

EMERGENCY MEDICINE—Level I Trauma Center. Major university teaching hospital is conducting a search for emergency department physicians. Excellent remuneration and challenging medical environment. Interested applicants should send resume to: Barry R. Trautman, HealthLine Physicians Services, 8401 Hanley Industrial Court, St. Louis, MO 63144.

CARDIOLOGIST, B/E, B/C: Looking for associate in the established practice of cardiology. Excellent opportunity; modern progressive hospital in an ideal southern family community. Reply to Box #2053, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL DIRECTOR: Accredited ambulatory health care organization has opening for medical director functioning as clinician and medical administrator. Administrative duties (approximately 10% of time) include supervision, medical policies, and adherence to accreditation standards. Full-time, 11 or 12-month position beginning July, 1987. Competitive salary and benefits, Illinois physician license, board eligibility/certification, and 3 years minimum in multi-physician clinic required. Prefer applicants with administrative experience. Contact Director, Student Health Service, Illinois State University, Normal, Illinois, 61761; (309)438-8655. To assure consideration, please apply by April 3, 1987. An Affirmative Action/Equal Opportunity Employer.

FAMILY PHYSICIAN wanted for salaried position in enchanting rural New Mexico. Small hospital, E.R., obstetrics a must. Community Health Center in Cuba, New Mexico, tricultural area, national forest setting. Skiing and mountain sports nearby. Board eligible/certified desired. Excellent benefits, malpractice paid. Write or call today: Physician for Cuba, c/o New Mexico Health Resources, P.O. Box 27650, Albuquerque, NM 87125; (505) 242-0633.

PHYSICIAN OPPORTUNITIES: Current opening full or part-time for BC/BE physician in family practice/internal medicine—solo, group or clinic based positions including Women's Health Center and/or Convenient Care Center. Salary excellent; malpractice and relocation expenses included. Located in 350,000 population area with family oriented environment. Please send curriculum vitae to: Constance Stahler, Franciscan Medical Center, 2701 17th Street, Rock Island, IL 61201; or call collect (309) 793-2200.

FAMILY PRACTICE PHYSICIAN—Board eligible or certified. Training/interest in obstetrics preferred. Full-time position available August '87 with established community health center in St. Louis. Contact V. Appoo Koenig (314) 241-2200, or mail resume to Grace Hill Health Center, 2500 Hadley, St. Louis, MO 63106.

ANESTHESIOLOGIST WANTED for permanent, part-time position at 185-bed community/area hospital in northwest Illinois community of 30,000. Currently have three full-time and one part-time anesthesiologists, and desire to utilize additional operating room daily. Plan is for three days per week, and vacation coverage. Call status negotiable. If interested, send resume to M. A. Belinson, M.D., Director of Anesthesiology Department, Freeport Memorial Hospital, 1045 West Stephenson Street, Freeport, IL 61032.

WISCONSIN—located on the scenic Wisconsin River. Full-time emergency position available with an established department which has growing volume ED visits. Independent contractual relationship. Flexible scheduling with annual compensation between 100k-115k. Previous ED experience with pediatric background desired. Write or call collect: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; (414)785-6500.

ASSOCIATED EMERGENCY ROOM Physicians has immediate opening for a qualified full-time physician in July 1987. We have stable contracts in two Racine area emergency rooms, in addition, staffing a staff in active urgent care. We offer career opportunities, flexible scheduling and a competitive salary package. John Linstroth, M.D., 1131 Sherwood Lane, Caledonia, WI 53108; (414) 835-7761.

INVASIVE CARDIOLOGIST urgently needed in midwestern university city. Draw from 150,000+ population base. Open lab with fully trained staff in facility with open heart surgery program. Enjoy competitive first-year guarantee plus productivity and benefits. Only highly qualified and aggressive individuals need apply. Send C. V. to James Russell, Inc., P.O. Box 427, Bloomington, IL 61702; or call (309) 663-9467.

CORRECTIONAL HEALTH SERVICES is seeking board-eligible or board-certified family practitioners and internists for full and part-time positions in Illinois Department of Corrections facilities. Occupational health: Also needed are experienced physicians in occupational health with emphasis on program development for established clinics with industrial base in Chicago area. For more information send C.V. to Stanley Harper, M.D., Correctional Health Services, 467 W. Deming, Suite 704, Chicago, IL 60614; (312) 883-8705.

EMERGENCY MEDICINE SPECIALIST—Associate trauma center seeks additional emergency medicine specialist to join its progressive team which serves a 202-bed hospital. Center has average of 1,350 visits per month. Highly competitive salary and full-range of fringe benefits. Reply with C.V. to Nels Calvert, M.D., Pekin Memorial Hospital, Court & 14th Streets, Pekin, IL 61554; or call (309) 353-0430.

FAMILY PHYSICIANS needed to fill career opportunities in Illinois. Practice sites located throughout Illinois and include all types of opportunities. For information send your C.V. to the Illinois Academy of Family Physicians, 1200 Harger Road, Suite 722, Oak Brook, IL 60521.

SITUATIONS WANTED

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box #2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS LICENSED MD, experience in GP, pediatrics, adolescent, and addiction. Looking for position in state, municipal or university centers, clinics, hospitals. Please call anytime (312) 652-7990.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED RADIOLOGIST, university trained, 10 years in practice, available for part time coverage of office, clinic, etc. after July 1 in Chicago area. Reply to Box #2049, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DIAGNOSTIC RADIOLOGIST: Board certified, interventional and imaging fellowships, experienced in all modalities, seeks locums short term. Available most weekends, some weeks including weekdays. Reply to Box #2051, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL PRACTICE WANTED: Physician wishes to buy existing general medical practice preferably in DuPage county or nearby. Call (312) 983-0773 after 7:00 p.m.

FOR SALE, LEASE OR RENT

FOR RENT: Beautiful and well furnished office for rent for any specialty in growing area of Carol Stream, IL. Call (312) 830-3000 after 5:00 p.m.

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

SELLING FAMILY PRACTICE Southside. Grossing $125,000. Working 3 hours. More potential if fulltime devoted. Selling cheap with equipment. Relocating. Excellent office. (312) 333-6789 evenings/weekends.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)662-1664 or (312) 244-3357.

DES PLAINES. Medical suite in beautiful Lee Street atrium building. Waiting room, reception, offices, two exam rooms. Newly carpeted. Competitive rental plus attractive move-in bonus. Shaker. (312) 524-0800.

WELL-ESTABLISHED PEDIATRIC practice for sale. Located central Illinois. Medium size community. Will introduce up to one month. Grossing over $200,000. Reply to Box #2046, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE: Well-established general practice grossing approximately $175,000. Cahokia, IL—close to St. Louis, MO. Fully equipped medical clinic (approx. 2,800 sq. ft.) also available. Spacious waiting area, 7 exam rooms, large parking lot, clerical office with vault, private doctor's office, lab, x-ray. Call Magna Trust Company (618) 233-2120, ext. 22.

FAMILY PRACTICE Grossing $150M and office building in $3mil, 5 acre professional complex for sale. 1800 square feet, fully equipped, 5 exam rooms, beautifully landscaped. Located in Modesto with easy access to San Francisco. Available now. Contact: Emile Lengyel, M.D., 4141 Carver, Modesto, CA 95356; (209) 522-2544.

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GENERAL INTERNIST. Invest in yourself! One suite remaining in new medical building with numerous specialties now represented. Located in university town in Dunes country of southern Lake Michigan, fifty miles from Chicago. Superior schools, many recreational opportunities, small town atmosphere. Join other physicians now in independent private practice. Achieve your optimum potential by beginning your own practice in this beautiful new building. Complete lab and x-ray. May invest in building or rental available with large subsidies for beginners. Three minutes from 400-bed hospital with all medical facilities. Contact: Thomas J. Covey, M.D.; (219) 462-4167.

FOR SALE: 30-year family practice grossing over $350K/year in central Illinois. Includes house, full office facilities, medical supplies and equipment. Retiring doctor willing to negotiate. Please send inquiries to Box 2055, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602; or call (312) 303-0043 after 6:00 p.m.

CHICAGO, WEST GRAND AVE. Owner anxious to retire. General practice. Grossing $45,000, asking $25,000. Professional Practice Sales, 540 Frontage Rd, Northfield, IL 60093; (312)441-6111.

MISCELLANEOUS

PHYSICIANS—EMC*EXPRESS,™ General Electric's electronic medical insurance claim delivery service, is now available. Fully computerized accounts receivable management. Office Resources (815) 664-2567.

MEDICAL PRACTICE SALES and appraisals. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004; (215) 667-8630.

DISCOUNT HOLTER SCANNING Services starting at $35.00. Spacelabs holter recorder (cassette) available from $1275.00. Cardionostic holter recorder (cassette) available from $995.00. Smallest and lightest holters update. Fast service (24-48 hrs turn over). Hookup kits starting at $4.95. Special introductory offer of three free tests with any purchase or lease of the recorder. Cardiologist overread available for $15.00. If interested call (301) 870-3626.

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Planning Ahead



I eagerly look forward to my year as spokesperson for Illinois State Medical Society members. During my tenure as trustee, I have learned to value the excellence of our staff. With their capable assistance, I pledge to do my best to communicate physicians' views to the public.

I will also strive to facilitate communication within our membership: between ISMS leadership and members, and between members themselves.

To better plan future priorities and communicate them, the Illinois State Medical Society has taken the last year to review and revise our long range goals and objectives. Three major areas of ISMS programming goals are being updated to meet current challenges: communications and public relations, membership, and education. While organized medicine has made great strides in each of these areas over the last few years, the ISMS Planning and Priorities Committee believes still more attention and focus is warranted.

In the area of communications and public relations, your state medical society will continue to devote its resources toward taking pro-active, aggressive stances on key public health issues. You are an important ingredient in this effort. In your area of clinical expertise, I urge you to offer your spokesmanship to your county and state society. ISMS also needs skilled local advocates to speak out on socioeconomic issues facing medicine and our patients today—issues such as Medicare, medical malpractice reform, and others. Many of you have offered your time and energies in doing so. I encourage those of you who have not to consider it.

In the area of membership, ISMS will continue to look at potential new programs and benefits for you. While liability insurance and legislative representation still rank high on our Society's list of concerns, we are investigating expanded programs to offer members and prospective members practical information and benefits to assist in the practice of medicine.

In the area of education, ISMS is looking toward broadening these programs and making them more accessible to members in all of Illinois' far reaching locales. Strengthening communications between our organization and Illinois' medical academia is also important.

I encourage you to offer your thoughts and ideas on how we might better achieve each of these goals. Provide input to ISMS leadership through your county or branch society, or your ISMS trustee. We need and want your ideas as we continue to develop, implement and update Society programs. Only your continued commitment will keep ISMS a vital, valuable source of advocacy for physicians and the public health in Illinois. ◀



Allan L. Goslin, M.D.
President

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Alcoholism and Substance Abuse (DASA)

Substance Abuse Education Program

DASA has awarded a grant to ISMS to conduct programs and develop materials for physicians on the topics of cocaine treatment and appropriate prescribing and recordkeeping of controlled substances.

The programs are offered at no cost to medical staffs and medical societies. Groups or individuals interested in hosting seminars or receiving information on these topics should contact the ISMS Division of Educational and Medical Services.

New Office for the Triplicate Prescription Program

The DASA Triplicate Prescription Control Program in Springfield has moved to a new office. Inquiries or information concerning the Triplicate Program outside the Chicago area should be directed to: DASA, Triplicate Prescription Control Section, 222 S. College, 2nd Floor, Springfield, IL 62704; 217-782-0685. In Chicago, DASA is located at the State of Illinois Building, 100 W. Randolph, Suite 5-600, Chicago, IL 60601; 312-917-3840.

Talwin NX

As of November 6, 1986, the prescription drug Talwin NX has been moved from a Schedule II designated product to a Schedule III non-designated product under the Illinois Controlled Substances Act. Due to this change, Talwin NX no longer requires a triplicate prescription form. Please note: Talwin and Talwin Lactate still require a triplicate prescription form, since they remain Schedule II designated products.

Methylphenidate/Ritalin

The DASA Advisory Council is considering a recommendation to reschedule Methylphenidate/Ritalin from a Schedule III non-designated product to a Schedule II non-designated product. This move, being done to align the Illinois classification with the Federal Controlled Substance Act, would not require any change in the procedure of physicians.
(Source: DASA correspondence from Director William Atkins, 2/12/87)

From the Department of Children and Family Services (DCFS)

Self-Help Groups for Parents of Emotionally Disturbed Children

DCFS, in cooperation with the Department of Mental Health and Developmental Disabilities, has federal funds available to assist in the development of self-help groups for parents of emotionally disturbed children. The groups give parents the opportunity to share common concerns, provide mutual emotional support and enable them to learn more about mental illness and the services available for the child and family.

For further information on creating a group or referring your patients to a support group, contact Donna Simonson, DCFS, One North Old State Capitol Plaza, Springfield, IL 62701.
(Source: January 21, 1987 correspondence from D. Simonson, DCFS)

Child Abuse Education Program

DCFS has awarded a grant to ISMS to conduct seminars and develop materials for physicians, medical societies and medical staffs on recognizing and reporting child abuse and problems with handicapped infants. Persons wanting to attend or host programs or receive materials on these topics should contact the ISMS Division of Educational and Medical Services.

From the Department of Public Health (IDPH)

Development of Cancer Data Proposal

IDPH plans to submit an application to receive federal funds for support of a statewide cancer data collection

(Continued on page 260)



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C I B A

(See Brief Summary of Prescribing Information on the next page.)

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INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26) *100 Systems (NDC 0083-2105-30)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

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C I B A

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

Action Teams and the Media

Previous PLI Update columns in *IMJ* have focused on meetings between physician action teams and legislators. The purpose of such meetings has been to encourage legislators to support a cap on non-economic damages awarded in malpractice cases and a revised statute of limitations for suits involving treatment of minors.

While critically important to the success of the medical community's latest initiative, meetings between physicians and legislators are not always enough to gain the lawmakers' support. Therefore, many action teams are busy with another important aspect of the drive for further malpractice reform—seeking support from their local news media.

Media support was a key factor in convincing legislators to adopt most of the reforms offered by physicians in 1985. Gaining support for this year's efforts will be equally important. However, media support probably will be much more difficult to obtain due to the more emotional aspects of the issues and better organization on the part of opponents.

Nonetheless, physicians have been working hard to get the backing of local newspapers and broadcast outlets. In Rockford, ISMS 12th District Trustee Dr. Raymond Hoffmann was interviewed in February by a local TV station regarding the issue of physician discipline. Dr. Hoffmann responded to charges by local consumer groups that the malpractice problem was the result of lax physician discipline.

Also in Rockford, Dr. Hoffmann and Dr. Robert Behmer, president of the Winnebago County Medical Society, were interviewed jointly on WREX-TV's "Forum 13" program following an ABC network program on malpractice. They appeared on the program a second time to debate a representative of the self-designated Illinois Coalition on Consumer Rights.

In Waukegan, Dr. Gerald Frank appeared on WXLC Radio's "Talk Back" program. Dr. Frank discussed further tort reform with the program's moderator and fielded questions from the listening audience.

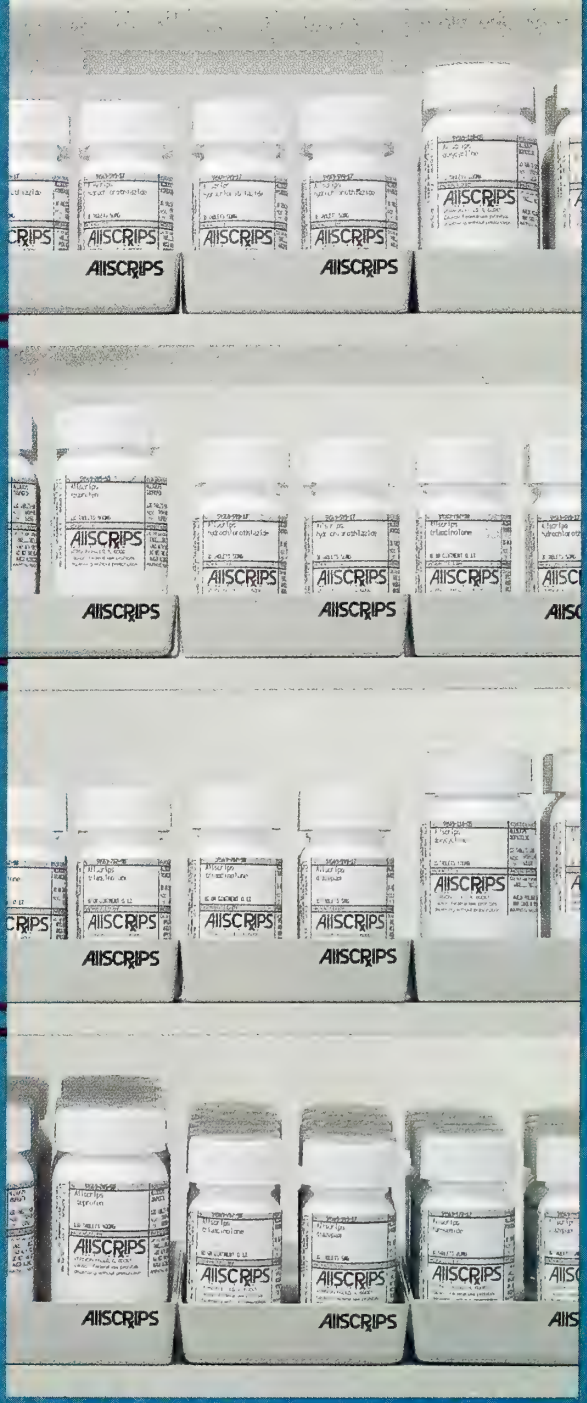
To better prepare physicians for interviews with reporters and editorial boards, Illinois State Medical Society staff conducted media training sessions for physicians and members of the ISMS Auxiliary. Four-hour sessions were held for the Winnebago County Medical Society in Rockford on February 23, for the Chicago Medical Society at ISMS headquarters on February 24, for the Sangamon County Medical Society in Springfield on February 26, and for the Madison and St. Clair County Medical Societies in Collinsville on March 4.

Media training at the county medical society sessions also focused on another critical issue expected to arise during the current session of the Illinois General Assembly. That is the legislature's "sunset review" of the Medical Practice Act.

Because of the Act's importance to every physician and his or her patients, and because of possible amendments proposed by groups seeking modifications of their own allowable practices, ISMS is distributing a media information kit to every daily newspaper, radio station and television station in Illinois. ◀



Rockford physicians and attorneys debated the causes of Illinois' malpractice crisis on a recent edition of WREX TV's "Forum 13" show. Pictured left to right are: "Forum 13" hosts Peggy Finnegan and Chuck Colley; ISMS Trustee Raymond Hoffmann, M.D.; Winnebago County Medical Society President Robert Behmer, M.D.; and Rockford plaintiff attorney John Boreen. Also appearing (but not shown above) was local defense attorney Gregory Guth.



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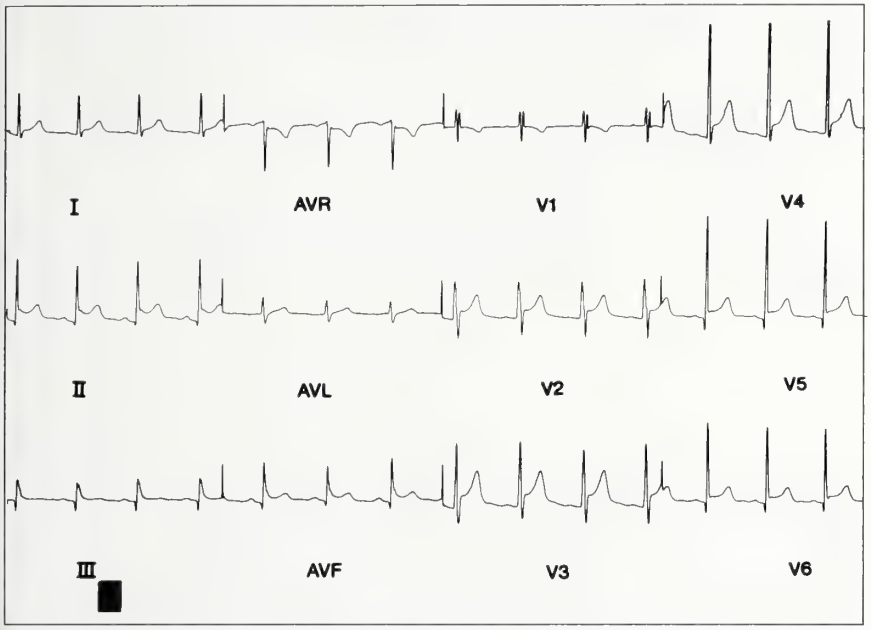
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CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This patient was a nineteen-year-old man who complained of severe chest pain for the past three days. The pain increased with inspiration and sitting upright. It was described by the patient as stabbing-like, and radiated from the retrosternal chest to his back. The patient first noticed the pain three months earlier while he was running. Still, he was able to complete the cross-country running season. When the pain worsened, he sought medical care.

There was no past medical history of heart trouble in the patient or his family. Physical examination showed a healthy-appearing young male with a blood pressure of 120/80mmHg and a pulse of 84 beats per minute. Chest and back were normal. His lungs were normal. The heart had a normal first heart sound and a widely split second sound. There was a grade 3/6 systolic crescendo-decrescendo murmur loudest at the left sternal border. The patient did not know he had a heart murmur. The remainder of his physical exam was normal. This twelve lead ECG was obtained.

Questions:

1. **The twelve lead ECG show(s):**
   - A. ST segment elevation compatible with an injury current.
   - B. ST segment elevation compatible with pericarditis.
   - C. ST segment elevation compatible with early repolarization.
   - D. Right ventricular hypertrophy.
   - E. Acute inferior-lateral myocardial infarction.

2. **Treatment of this patient could include:**
   - A. An echocardiogram.
   - B. Admission to a coronary care unit.
   - C. Serial cardiac enzymes and ECGs.
   - D. Cardiac catheterization.
   - E. All of the above.

(Continued on page 262)

Membership Forum is intended to serve as a communication tool for ISMS membership. The editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, Twenty N. Michigan Ave., Suite 700, Chicago 60602.

PAC Contributions: Nay!

Dear Sir:

The Illinois State Medical Society routinely asks physicians to contribute to its Political Action Committee (PAC), funds from which are used to support legislators friendly to physician interests. From one point of view, this seems an eminently reasonable thing to do. We should be aware, though, that there exists another point of view, promoted, for instance, by Common Cause, which holds that PACs are a form of institutionalized corruption and should be abolished.

Despite whatever view one takes of PACs in general, there are excellent reasons why physicians may not wish to contribute to the Medical Society's PAC. The issues that concern us as individuals, as physicians, and as citizens are many. Examples include the question of divestment in South Africa, the quality of education in public schools, the availability of safe abortions, enforcement of equal opportunity provisions, cuts in nutritional programs, military spending, the status of Haitian and Central American refugees, and gay rights. For the most part, these issues will have less direct effects on our pocketbooks than professional liability reform. But that does not mean that we can afford to ignore them in deciding to whom we will give our votes and our money. And they are not issues on which either the members of the Society or our friendly legislators hold uniform views.

Physicians try to project an image of ourselves as people whose first concern is the good of our patients, followed, when the two are not in conflict, by the good of society, and whose self-interest is enlightened and reasonable. In order to live up to this image, we must be willing to make difficult choices when not all of our various loyalties and principles can be served at once. This is best done by each physician evaluating each candidate on the basis of her or his entire range of qualifications. ◀

Sincerely,

Anne Scheetz, M.D.
Member, Illinois State
Medical Society

Editor's Note: A corresponding viewpoint is presented in the Guest Editorial on the adjacent page.

PAC Contributions: *Aye!*

This is a response to a letter by Dr. Anne Scheetz which appears in the Membership Forum on the opposite page.

The Illinois State Medical Society Political Action Committee (IMPAC) is a voluntary organization. Its purpose is fourfold:

1. To promote improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in it;
2. To encourage physicians and others to understand the nature and actions of government, both on important political issues and on the records of officeholders and candidates;
3. To assist physicians and others in organizing for more effective political action and in carrying out civic responsibilities; and
4. To do any and all things necessary or desirable for the attainment of the purposes stated above.

Since its inception in 1960, IMPAC has encouraged its members to become actively involved in the affairs of all levels of government. This involvement need not, and should not, be limited to medical issues, but rather, should be a well-reasoned and practical contribution to community welfare.

As we celebrate the 200th year of our Constitution, we should remind ourselves that one of its Bill of Rights is freedom to associate freely. Historically this freedom has significantly contributed to the development of our country, as individuals with a common purpose have joined together to participate in the democratic process. This organized action serves as a stimulus to the democratic process, since individuals alone have a limited impact on our governmental entities.

IMPAC membership should be a priority for every physician—but not a bar to membership in other organizations with interests different and some times conflicting to medicine's. As conflicts do arise it is vitally important that both sides of an issue be represented, so that proper resolution is accomplished. This has been the essence of our legislative process for 200 years and has allowed for the orderly conduct of government.

Groups who propose to limit or abolish organized political activity fail to realize the importance of this participation to the survival of democracy. No matter what issue comes before our Congress or state legislature today, we can be assured that opposing viewpoints will be heard. If organized political action groups were abolished, both this assurance and our democratic institutions would suffer the consequences.

I encourage you to stay active in the many causes you note in your letter. But do not forget that organized and individual political activism is the cornerstone of our democracy. Your contribution to IMPAC will help assure that those who understand and foster quality medical care in Illinois are elected to promote it.

George T. Wilkins, Jr., M.D.
Chairman
IMPAC

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Regional rather than systemic areas of painful osteoporosis are described in 56 patients with a median age of 48 years. Thirty-three of these patients were male and 23 were female. The lower extremity—particularly the hip joint—was most often involved. No evidence of synovitis, manifested clinically by mono- or oligoarticular pain aggravated by weight bearing, was noted at rest or at night. Radiological and bone scan findings confirmed this. Treatment consisted of joint protection, gradual ambulation, and nonsteroidal anti-inflammatory agents. The osteoporosis resolved spontaneously within a few months. (Lakhanpal, S., *et al.*; *Ann Int Med* 106:3,444-50, 1987)

The Centers for Disease Control reported 22,201 new cases of tuberculosis in 1985. Fifty-two percent of those afflicted were white, 48% were non-white. The rate for non-whites was 5.2 times higher than that of the white population. The 25-44 year age group had the highest incidence of morbidity and the mortality rate for non-whites was 3.7 times higher than for whites. Among non-Hispanic whites the highest incidence occurred between the ages of 70-74. (*Div Tub Control, Morbidity and Mortality Weekly Report* 36:6, 1987)

Travelers' diarrhea was noted in 40% of 182 students traveling through Mexico and receiving a placebo. It was found in 24% receiving one tab of 262mg bismuth subsalicylate four times per day, and in 14% receiving two tabs four times per day. The diarrhea was caused by the enterotoxin *Escherichia coli.* The bismuth subsalicylate was well tolerated, though blackening of the stool and tongue was noted in some. In both dosages, mild tinnitus was reported in an insignificant number of cases, lasting approximately 1.2 days per 100 days of treatment. Two tablets were recommended four times daily as a safe and effective means of reducing the occurrence of travelers' diarrhea among persons at risk for periods of up to three weeks. (DuPont, H., *et al.*: *JAMA* 257:10,1347-50, 1987)

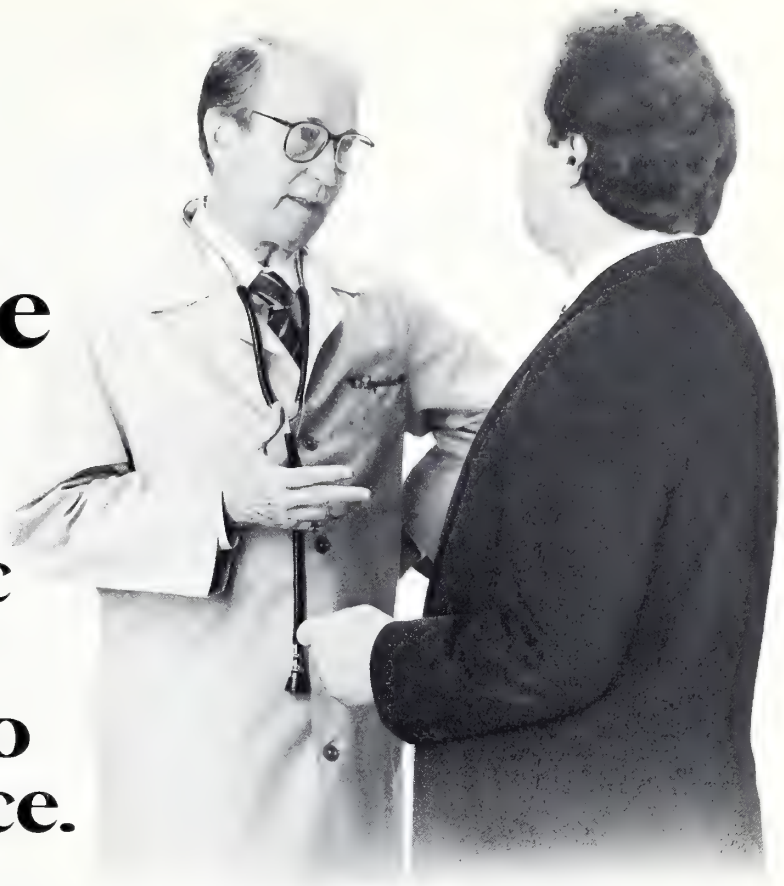
Fecal blood loss was evaluated in 68 healthy volunteers who had taken aspirin and consumed alcohol. Fecal hemoglobin concentrations were measured before and after the drug and alcohol ingestions with the hemoQuant assay. Aspirin doses of 975mg daily, or ethanol 300cc of 5% or 30cc of 50% three times nightly, or both, were administered. Some hemoQuant levels approached five times the normal levels after three days of maximal doses of aspirin and alcohol administered concomitantly. For short durations of 1-3 days no significant increase in fecal hemoglobin was noted by the addition of alcohol to the ingestion of aspirins. Thus, social consumption of ethanol is unlikely to interfere with fecal blood testing, but therapeutic doses of aspirin will interfere. (Fleming, J., *et al.*: *Mayo Clin Proc* 62:3,159-63, 1987)

The treatment of parkinsonian syndromes with levodopa has achieved remarkable results for years. Fluctuations in efficacy and side-effects, as well as ineffectiveness after prolonged usage have lead to studies for possible gastrointestinal absorption abnormalities. Eleven patients were placed on a modified low protein diet after experiencing excessive involuntary movements or bradykinesia with tremor, though on an L-dopa-carbidopa regimen. Marked relief of symptoms was noted in 82% of patients, while 18% experienced mild to moderate relief. Protein supplementation was reserved for the evening meal. (Pincus, J., Barry, K.: *Arch Neurol* 44:3,270-72, 1987)

Official mortality statistics of male physicians in Finland between 1971-80, compared to the general population, showed lower death rates for physicians from cardiovascular disease, tumors, causes amenable to medical intervention, accidents and violence—but not suicide. The authors suggested that comparisons would be more appropriate if populations were matched educationally and economically. Only managing directors and those in legal work had as high a mortality rate as physicians. The death rate for architects and engineers was significantly lower. Physicians appeared not to use their professional knowledge and skills to reduce their own mortality risks, and showed a higher risk for mental rather than physical or chemical hazards. (Rimpela, A., *et al.*: *The Lancet* Volume 1: 8524,84-86, 1987)

A double blind study on the effects of estradiol with progesterone, oral 2000gms of calcium, and a placebo was attempted in 43 women with early postmenopausal bone loss. These patients were followed for a period of two years. Bone mineral content was tested in the forearm by single-photon absorptiometry and in the entire body and spine by dual-photon absorptiometry. The bone mineral content remained constant in the estrogen-treated group, but decreased significantly in the placebo group. Those taking oral calcium showed a slowed rate of loss in the compact trabecular bone, but no change occurred in the trabecular bone loss compared to the placebo group. (Riis, B., *et al.*: *N Engl J Med* 316:4,173-7, 1987)

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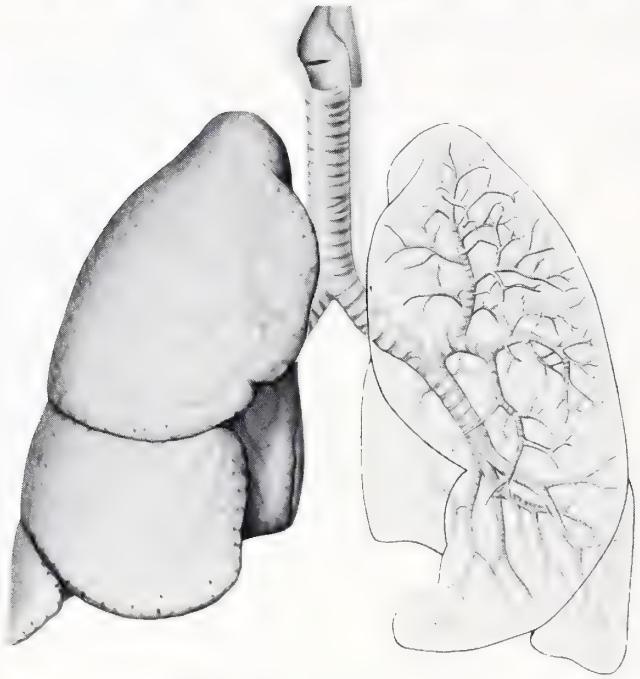
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Administer cautiously to allergic patients

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
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Second Annual Meeting

The Second Annual Meeting of the Illinois State Medical Society's Hospital Medical Staff Section was held on Saturday, February 28, 1987 in Chicago. A total of 52 hospital medical staffs were represented at the meeting, 29 from Cook County and 23 from Downstate. The meeting was divided into a business session and an educational session. The educational portion of the program was co-sponsored and approved by the Chicago Medical Society for two hours of Category 1 continuing education credit.

The morning session consisted of three educational presentations. The first presentation was given by special guest and keynote speaker, Howard L. Lang, M.D., chairman of the American Medical Association's Hospital Medical Staff Section. Dr. Lang discussed past achievements and current concerns of the AMA's HMSS. He stressed the need to resolve disputes surrounding medical staff credential files, such as who has accessibility and ownership rights. In addition, Dr. Lang discussed DRGs and PROs and urged continued involvement in these and other issues relating to the hospital medical staff.

Alfred J. Clementi, M.D., chairman of ISMS' Ad Hoc Committee on the Re-write of the Medical Practice Act, addressed the Section on the current Professional Liability Initiative by the ISMS and the Illinois State Medical Inter-Insurance Exchange seeking to establish a $250,000 cap on noneconomic awards and a reasonable statute of limitations for minors to file claims and suits alleging medical malpractice. In addition, Dr. Clementi discussed the Medical Practice Act, which will be reviewed this year by the Illinois General Assembly. Dr. Clementi stressed the importance of physicians becoming active in the legislative process through participation in their hospital or county action team, which acts as liaison to legislators, the community and local media.



Howard L. Lang, M.D., chairman of the AMA's Hospital Medical Staff Section, addresses the ISMS HMSS on current activities of the AMA's HMSS.

Lastly, Robert M. Vanecko, M.D., president-elect of the Chicago Medical Society and board member of Crescent Counties Foundation for Medical Care (Illinois' PRO), and Thomas R. Hyngstrom, Ph.D., its executive director, outlined for the Section the Quality Review and Sanction Process. Dr. Hyngstrom estimated that only a small number of Illinois physicians will be sanctioned in the next two years, and denied rumors that HCFA requires a quota of sanctions from PROs.

During the afternoon, the ISMS HMSS conducted its business ses-

sion. The Section reviewed two resolutions. The first resolution was approved by the Section and will be submitted to the AMA's HMSS for review at its June meeting. The resolution proposes that Standard 10.3.7 in the JCAH's *Accreditation Manual for Hospitals* be amended so that hospital clinical departments or major clinical services be required to hold a meeting every other month, rather than on a monthly basis. The second resolution, submitted by Pedro A. Poma, M.D., to the ISMS House of Delegates for review in April, was unanimously supported by the Section. This resolution proposes establishment of a policy on confidentiality and utilization review, and recommends that a similar resolution be brought before the next meeting of the AMA's House of Delegates.

The Section also held elections for six of the ten HMSS Governing Council positions. Based on nominations from the Cook County and Downstate caucuses, the Section voted unanimously to elect the following individuals into office for a two-year term: Joseph L. Murphy, M.D., chairman; Silvana Y. Menendez, M.D., vice chairman; Dennis M. Brown, M.D., delegate; Raymond A. Dieter, Jr., M.D., alternate delegate; Jaroslav F. Neskodny, M.D., at-large member; and Warren D. Tuttle, M.D., at-large member. The remaining four Governing Council members are: Allan L. Goslin, M.D., treasurer; Thomas C. Malvar, M.D., secretary; Lawrence A. Stone, M.D., at-large member; and Albino T. Bismonte, M.D., at-large member.

The ISMS HMSS typically meets three times each year, once for the annual business session and twice in caucus form in conjunction with the AMA HMSS annual and interim meetings. The next meeting of the ISMS HMSS will be during the AMA Annual Meeting, June 18-20, 1987.



Joseph L. Murphy, M.D., incoming chairman of the ISMS HMSS Governing Council, presides over the Business Session of the ISMS HMSS's Second Annual Meeting held February 28.



James H. Andersen, M.D., and members of the ISMS HMSS Governing Council, Albino T. Bismonte, M.D., Silvana Y. Menendez, M.D., and Warren D. Tuttle, M.D., at ISMS HMSS's Annual Meeting.

All Illinois hospital medical staffs are eligible to have one voting representative in the ISMS HMSS. Representatives must be ISMS members with active clinical privileges, and should be elected by the medical staff. Representatives to the AMA HMSS are automatically members of the ISMS Section unless the medical staff decides otherwise. The ISMS HMSS Governing Council strongly encourages each hospital to elect an HMSS representative. If you would like further information regarding ISMS HMSS activities or membership, please contact ISMS HMSS at (312) 782-1654.

SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY
RICHARD J. ABLIN, PH.D., CONTRIBUTING EDITOR

Issues on Stress, Immunity and Aging

Immune Systems and Neuroendocrines

BY EDWIN L. COOPER, PH.D./LOS ANGELES, CALIFORNIA

We all know the word "stress" and associate it with the modern lifestyles most of us live. Producing tension and urgency is real, yet we are only vaguely aware of what this may do to our bodies. To many, immunity means the body's defense against infections, and somehow we are certain, even without proof from experiments, that lowered resistance due to stress affects our body's efficiency in handling infectious pathogens. Elderly people also have understood over the years that there are real connections between lowered resistance due to stress and what they often experience as a natural consequence of age. How, then, are stress, immunity and aging interrelated? Is it by interconnections via cells or cell products such as antibodies and hormones, or is it affected by a combination of these intercommunicative components? Each of these three subjects is worthy of a separate mini-review, but I shall attempt to interlock them by revealing the outcome of their interactions.

Two important historical sketches concerning research on stress and infectious disease will be reviewed, followed by explanations of the basic features of the immune system, the neuroendocrine system, and aspects of how the environment may affect responses. Basic aspects of the immune system will deal in general with cells, tissues, organs and their functions. The neuroendocrine system, presumably the area where central controls (possibly for even the immune system) may reside, reminds us of how stress caused by neuroendocrine changes can influence the immune system, *i.e.*, the diminution of lymphocytes, central characters in the whole immune response scenario. A most provocative area is concerned with biorhythms, and how these may affect the immune system, emphasizing important environmental forces (*e.g.*, sun, time).

Whether aging lymphocytes can be stressed, and the effect of that on immunity will be considered next, along with the effects of acute and/or chronic stressors on different parameters of lymphocyte function. Stressors include electric shock, mild restraint, repeated ether anesthesia, intermittent noise and exposure to low ambient temperature in carefully-monitored animal experiments, or in humans, the effects of bereavement.

Another topic related to hormones, aging and the immune response will center around multidirectional interactions involving the brain-centered triad of stress, mood and emotion, and how these collide with other hormones, receptors and lymphocytes. With respect to hormones and lymphoctyes, one unusual area will deal with the thymus and the reproductive system, a major departure from the earliest known functions attributed to the thymus during the early 1960s, *i.e.*, necessary for normal perinatal development of the immune system. In contrast, the thymus, as a producer of hormones, now seems to be equally involved with the reproductive system, connecting it to both the immune and neuroendocrine systems.

Learning how the neuroendocrine and immune systems work has come from experimental analysis, providing us with results that allow speculation on the subjects of immunomodulation, immunorestoration, stress and disease, with the thymus at the center influencing the immune response via thymosin peptides and, in turn, the central nervous system. As another source of modulation, we will consider neurotransmitters, hormones and inflammatory mediators in relation to lymphocytes, macrophages and granulocytes. One approach will deal with the effects of isoprinosine that may be able to reverse senescence and thereby maintain the immune system as it once was in young adults.

Finally, reviews of perspectives on immunity, aging and disease and the prospects for immunorestora-

tion in the treatment of immunodeficiency arising from aging and stress are presented. In a sense, senescence may be viewed as beginning with ontogenetic development, then neonatal life and puberty, followed by adulthood and the more obvious signs of senescence, revealing a progressive decline in the immune system as we age. On the more optimistic side, we are struck by evidence that prolonged lifespan can be induced by dietary restriction which, as a consequence, has been shown to increase certain lymphocyte functions and simultaneously decrease the incidence of spontaneous tumors. We are left with the prospect of increased information that will arise after investigation of the relationship between the neuroendocrine and immune systems, and how aging may affect the inter-relatedness of these two systems. The first major treatise dealing with aspects of immunity and the neuroendocrine system was compiled by Ader, a pioneer in the field.[1] More recently, another publication has reunited some of the same workers in order to present their most up-to-date findings.[2]

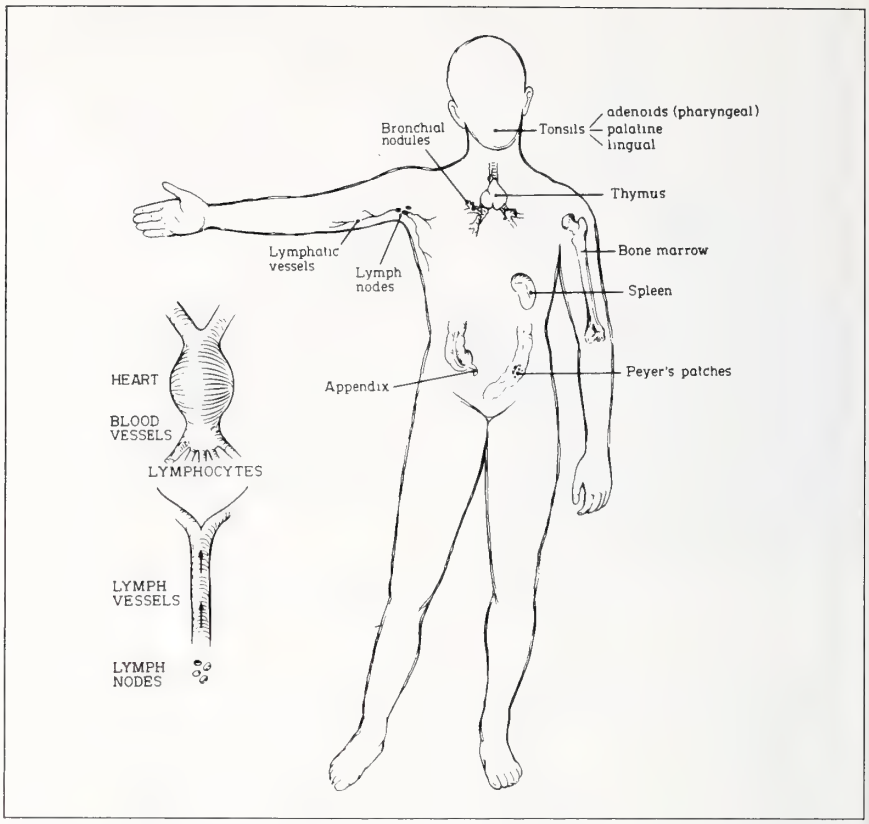


Figure 1
The immune system is composed of cells, tissues and organs that are connected by blood and lymphatic vessels, making it an extensive network.

History of Research

The general relationship between the immune system and the neuroendocrine system was discovered as a result of early work at the University of California at Los Angeles. Many physicians and pathophysiologists strongly suspected that stress influenced resistance to infection, but there was also wide skepticism due to a lack of evidence from controlled experiments. Rasmussen and his colleagues set out to establish this hypothesis. Most of their experiments used an avoidance-learning situation consisting of batteries of Miller shuttle boxes automatically programmed to train mice to jump back and forth across a barrier every five minutes for six hours in order to avoid an electrical shock which was preceded by a warning light and buzzer. Although the mice soon learned to avoid the shock, this procedure was stressful, as evidenced by hypertrophy of the adrenal cortex, leukopenia primarily due to a reduction in lymphocytes, hypotrophy of the spleen and thymus, and persistent pseudoestrus without ovulation in females.

Changes were induced also in the immune system by two other procedures: confinement by loosely wrapping mice in wire screen; or by exposure to noise, 800cps sine wave sound at about 120db intensity for three-hour periods daily. As a result of decreased immuno-efficiency, such mice showed increased susceptibility to herpes simplex, poliomyelitis virus, Coxsackie B virus, and polyomavirus infection.

In contrast, stressed mice, but not adrenalectomized mice, appeared to be slightly protected against Rauscher leukemia. Stressed mice also showed a decreased clearance of foreign particles from the blood, a delay in the rejection of skin grafts, suppression of granuloma formation, a pronounced decrease in susceptibility to acute passive anaphylaxis following the administration of antigen-antibody complexes, and a decrease in circulating interferon levels. Since attempts to extend these studies to primates were discouraging, no studies were done in humans. However, immunologists are revealing striking interrelationships between the brain and the immune system.

The work of Solomon has dealt more specifically with humans. It involves ideas united with philosophy and aided by certain experimental results to explain the relationship between emotions, immunity, disease and possible relationships to aging. It provokes the following question: Should the central nervous system (CNS) and the immune system really be linked by several hypotheses subject to experimentation despite a philosophical bent against such linkage? Both systems function as adaptive and defensive, relating organisms to the external world, and when imbalanced, produce disease. Inappropriate defenses in the immune system may be referred to as allergies, and in the CNS (the emotional system), neuroses. Reactions against self can occur in both systems. In psychiatry, according to Freud,

"retroflexed" hostility leads to depression, and in the immune system, autoimmunity.

Basic Aspects

Immunology

Immunology, a science formerly devoted to understanding the nature of infectious diseases, now clearly appears to encompass every facet of biology, borrowing conceptual and technical approaches from mathematics, physics and chemistry.[3] As a pragmatic discipline, it promises to help bioscientists find ways to treat certain human infectious diseases (*i.e.,* by the fabrication of vaccines) and other diseases such as autoimmune disorders.[4] As an experimental science, although solutions may be found, new problems will always present themselves. Thus, the work of immunology will never be completed in the empirical sense.

The capacity to distinguish *self* from *non-self* is one of the basic tenets of immunology. Recognition evolved as a primitive characteristic from less complex animals and reached an unsurpassed complexity of development in the human immune system. (Figure 1) The immune system is capable of effecting humoral immunity, the production of antibodies, and cellular immunity. The more primitive of the two immunities, cellular immunity may have evolved in addition to a safeguard against infectious disease, and also as protection against cancer. To do its job, our immune system has two major cell types, T- and B-lymphoctyes, that produce cellular and humoral immunity and macrophages, evolutionary relics of ancestral phagocytes.[5-8] All three together equip us with a systemic armamentarium, without which we would succumb to infectious diseases and perhaps cancer.

To induce an immune response, an entity which is *non-self* must be recognized. Antigens are those foreign materials to which an animal will respond. Although all animals somehow usually sequester antigen, their manner of ridding themselves of antigen differs. Variables that influence different responses include whether the antigen is soluble, particulate or cellular. The species, age and probably even the sex also influence the response. In addition, the amount of antigen, its route of administration, and whether it is soluble or combined with adjuvant, all greatly affect antigenicity and, therefore, immunogenicity, and whether it will be eliminated by antibody or other specific by-products of B- and T-lymphocytes. The specificity of antigen-antibody interaction, or what happens when an immune cell attacks a foreign cell, reflects the nature of forces responsible for initial recognition events that favor binding. The capacity of a substance to induce cellular interactions or antibody-formation is determined by the size and chemical nature of antigens. The antigenic determinants must therefore interface with T and B cells, and probably macrophages, in order to achieve a response.

As the immune system develops, it is first the yolk sac or its equivalent, and later the bone marrow that serves as sources of stem cells. Still later, such potentially immunologically-competent cells receive further instructions in the thymus or bursa of Fabricius in birds (or its analogue in other vertebrates) and differentiate into two immunocytes, the T cell and B cell. T cells affect cellular immune responses (*e.g.,* graft rejection) and B cells synthesize antibody. It should be emphasized that the impetus for developing the T and B concept of the two-component human immune system was fostered by understanding the discrete, dual, lymphoid organ system of birds (the thymus and the bursa of Fabricius). In doing so, an evolutionary approach to the science of immunology rewarded us with an understanding of our vestiges of immune competence, the macrophage, and what happened later in more complex animals, including fish, amphibians and reptiles.[5-8]

Neuroendocrinology

How do the immune and neuroendocrine systems interact by both real and hypothetical feedbacks? The earliest demonstrable effect of the neuroendocrine system on the immune system is the well-known depletion of lymphocytes by excess production of adrenocorticosteroids, a characteristic of stress. Coquelin and Gorski have outlined in the broadest sense what we seek to understand by the workings of the neuroendocrine system and how there may be "interspecific" controls linked to the immune system. In both instances, physiological processes, *i.e.,* immune and neuroendocrine phenomena, ultimately provide for the survival of organisms in a continuously changing world. Thus, cooperation of respiration, thermoregulation, fluid balance, muscular activity and other processes lead to a dynamic internal stability, an ideal state of homeostasis coordinated by the three major integrative systems: the nervous, endocrine and immune systems, all resulting from mutual harmony. (Figure 2)

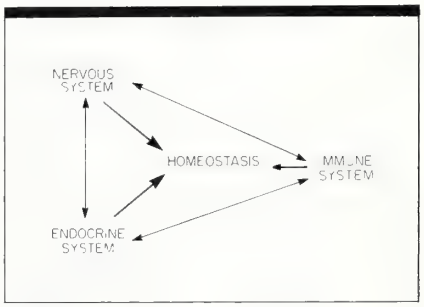


Figure 2
A schematic representation of the role of three integrative biological systems in the regulation of homeostasis.

Possible Interrelationships

Clearly, we know a great deal about one component of the homeostatic triangle, the unique interrelationships between the nervous and endocrine systems, the focus of neuroendocrinology. In relation to the immune system, the earliest indirect bioassay of adrenal cortical activity, lymphopenia, reveals the role of adrenal corticoids in immune function, suggesting that psychological factors causing psychic stress can modulate the immune system's activity. (Figure 3) With respect to aging, it has been postulated that age-related changes

in hypothalamic function (presumably neuroendocrine) could be central to the process of senescence.

Biorhythms

Do biorhythms include these two systems? Since light impinges upon the nervous system, it has been of interest to look at immune responses in relation to the sun and earth. Immunologic rhythms have not been studied extensively, perhaps because of difficulties such as sequential bleeding and the inutility of using telemetry, which is best for chronobiologists. Humans may be bled sequentially; however, such studies are difficult to execute. Immunologists interested in rhythms have studied primarily circadian rhythmicity, although few studies on circannual variations in immunologic parameters have been performed, including levels of IgA, IgG and IgM, during bimonthly periods for one year. Although there are apparently annual variations, analyses of circannual rhythmicity are complicated by the numerous events that take place during the course of a year, whereas fewer events occur during a 24-hour period. Disease(s), for example, may profoundly affect the immune system in general and lymphocyte blastogenesis in particular. (Figure 5) In their model, Shifrine and Rosenblatt present data from one human for whom there is a ten-year data base supporting annual variations in certain immunologic parameters such as cell-mediated immunity and humoral immunity, as well as in numbers of circulating leukocytes and lymphocytes. Mechanisms underlying such rhythmicity are unknown, as are the pacemakers of such rhythms. Nevertheless, existence of circannual rhythms in immunity raises some profound questions.

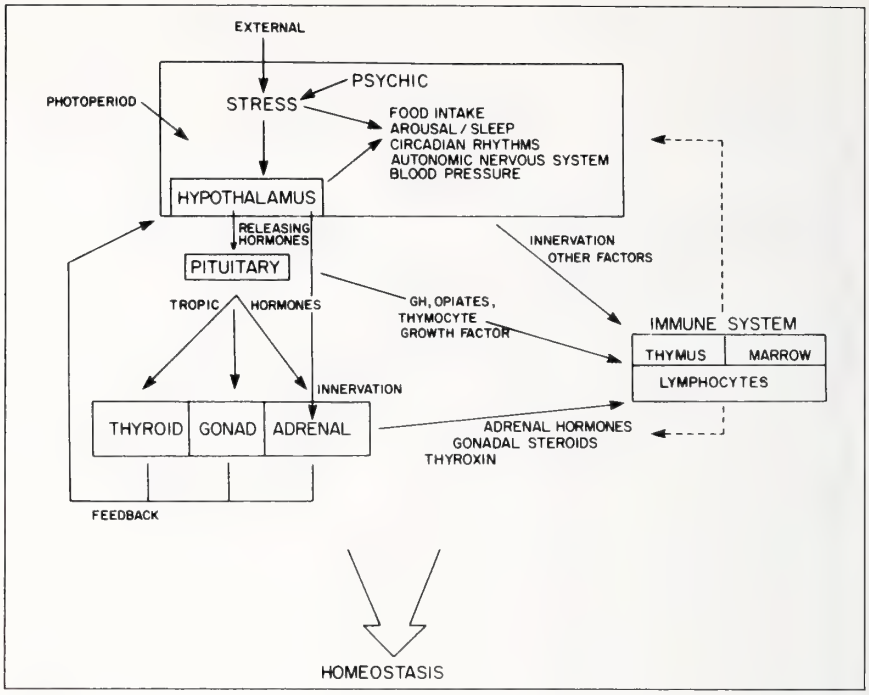


Figure 3
A schematic but more realistic diagram of some possible interrelations between the integrative systems involved in the maintenance of homeostasis.

Aging Lymphocytes

How do aging lymphocytes respond to stress and what kinds of immune responses develop? Psychological and/or neurological factors can modulate disease processes, but interest in the interaction between stress and immunity has recently become more active, especially the effects of various kinds of acute and/or chronic stressors on different parameters of lymphocyte function. On animals, chronic stressors included electric shock, mild restraint, repeated ether anesthesia, intermittent noise, and exposure to low ambient temperatures; bereavement and differences between the sexes in humans. Efficiency of immunologic function was measured by assaying the proliferative response of lymphocytes to various mitogens, including phytohemagglutinin (PHA), *Concanavilin A (Con A)*, and *E. Coli* lipopolysaccharide (LPS), and to autologous B cells. Stress did alter immune responses, usually causing a decreased proliferative response by peripheral blood or spleen lymphocytes. The *Con A* responsiveness of bone marrow cells increased as a result of stress, apparently as a result of T cells migrating to it. However, there are certain unexplained variations. For example, chronic stress could result in an ultimate increase in certain mitogenic responses of spleen cells, and differences have been observed between the responses of male and female subjects.

How stress affects immunity is far from clear; the neuroendocrine system, corticosteroids in particular, do affect lymphocyte function. Adrenal corticosterone secretion may not be required for stress-induced suppression of the PHA response of blood lymphocytes in rats, however, secretion probably does contribute to it. Methylprednisolone acts at the level of a stimulator cell in suppressing autologous mixed lymphocyte reactions. However, other hormones and a number of neuroendocrine active agents stimulate or suppress immune functions. There are certain apparently contradictory findings relative to the effect of stress on immune functions, and because of the enormous complexity of the three systems, some understanding is predictable. For example, stress affects lymphocyte activity by the interaction of three systems which regulate physiologic functions and homeostasis, and which themselves are highly regulated, *i.e.,* the nervous, endocrine and immune systems. Moreover, it is complicated to extend our understanding further because of

difficulties in devising experiments. For example, any study using human subjects may be somewhat difficult to control, but genetically defined strains may present other complications in studies of stress in animals.

We can devise appropriate controls for experimentally-stressed animals, but it is often difficult to define the unstressed state. Despite the fact that laboratory animals are usually bred and maintained throughout life in appropriate, properly supervised vivarium facilities, even the most acceptable vivaria are artificial and confining environments which can be noisy, subject to temperature fluctuations or even epidemics. Although assays on unstressed control animals are necessary for proper interpretations of changes in immune functions caused by stress, to define the unstressed animal presents the difficulty. In addition, the results emanating from studies on mice or rats may not relate to stress as it may affect humans. Thus, we can only generalize, at best, from one lymphoid organ to another. Finally, the intrinsic differences between immunological parameters (*e.g.,* T vs. B cell functions, mitogenesis vs. effector functions, etc.) and the complex regulatory interactions involved within each parameter further compound the problem.

Turning to the "aging lymphocyte," we refer to a lymphocyte from an aging organism, where during the normal aging process, alterations in many immune functions may occur, especially those of T cells. There is a general decline with age, but it may be differential due to the various T cell subpopulations (*i.e.,* increase or decrease in suppressor cells and helper cells, and similar changes in their respective functions). Since elderly individuals are more susceptible to infections than younger ones, stress may have a greater effect on old lymphocytes than on young ones, due to diminished function and a shift in their regulatory systems. In considering hormones, stress and age, several points should be mentioned. Corticotropin (ACTH) levels, released in response to stress, and response of the adrenal cortex to ACTH all remain unchanged with age. Plasma hormone levels do not change with age. However, glandular alterations decline in secretory and catabolic rates, and changes in target organ sensitivities do occur. Moreover, the hypothalamus and pituitary become less sensitive to negative feedback control. In addition, alterations in endocrine function could change the response to stress of the immune system in senescent individuals, confirming a suggested relationship between changes in the immune system and neuroendocrine function. Clearly more research is needed to determine: (1) differences between lymphocyte functions from young and old individuals during stress; (2) the kinetics of such changes and (3) how any alterations might be controlled by the neuroendocrine system.

Hormonal Effects

What hormones affect aging and the immune response? Most information concerning hormonal influence on the immune system centers around the thymic hormones, which form an intricate network of hormonal interactions that seem to affect not only immune functions, but reciprocal influences within the endocrine system, *i.e.,* pronounced effects of the thymus on the adenohypophysis, adrenals, the thyroid and vice versa. For example, thyroid secretions are known to regulate thymic functions, whereas deprivation of growth hormone in dwarf mice leads to an atrophic thymus, lymph nodes and lymphocytes in the splenic white pulp. Although precise interactions, as revealed by feedback of all sorts, are not clear, there is abundant evidence supporting the existence of coherent and balanced coordinating mechanisms, an area in need of intense research by immunologists. One such area might involve, for example, the specific targeting of certain cell populations within the immune system by specific hormonal agents.

The immunological model of sequential antigenic competition illustrates one aspect of non-specific suppression of the immune response in which presentation of one antigen interferes with immunization to a second antigen administered at defined intervals thereafter, and abolished by adrenalectomy or hypophysectomy. Antigenic competition has not been induced in mice 8-10 months and older, nor can thymocytes and spleen cells from 6-8-week-old mice transfer the response adaptively. Moreover, administration of non-immunosuppressive doses of cortisone acetate restored antigenic competition. Taken together, these results suggest an interesting series of responses during sequential antigenic competition. Antigen triggers release of ACTH from the pituitary activating corticosteroid production by the adrenal gland; this would directly regulate suppression of the immune response against the second antigen.

In another approach to suppression, circumstances causing stress might affect the immune suppressive system in a way analogous to the effects produced by senescence. Higher levels of prostaglandin in the human male may be a contributing factor to the male's generally shorter (than the female) lifespan. According to one interpretation, the decrease both in suppressor inducer T cell and suppressor precursor T cell function during senescence may be an immunodeficiency influenced by prostaglandin levels during aging and in periods of chronic stress. For the future, this work needs to be extended to identify the exact subpopulations and functional parameters of the affected T cells.

In more specific terms, one of the most fascinating relationships now known is that which exists between the thymus and the reproductive system, clearly extending the influence of the thymus beyond the immune system in determining the reproductive lifespan of females. As a first example, thymic peptides may play a role in releasing gonadotropins, which will then determine the rate oogonia are released from the ovary. Second, premature ovarian failure can also develop in mice that undergo neonatal thymectomy. Third, athymic mice have severe deficiencies in reproductive function. According to an acceptable interpretation of action, the thymus is implicated in a direct effect on the hypothalamopituitary axis in the following man-

ner. Thymic peptides stimulate the secretion of luteinizing-releasing factor and luteinizing hormone during important periods of development. In addition, thymic peptides may influence the secretion of other hormones and neurosecretory products, producing a complex relationship among products of the immune, neurologic and endocrine systems. It is intriguing that certain thymic peptides may be present in more primitive animals such as earthworms and frogs.[10]

Certain cells of the immune system may respond to specific hormones. That females are more susceptible to such autoimmune conditions as systemic lupus erythematosus can now be attributed to the markedly opposite effects of androgens and estrogens. Androgens induce a state of suppression in several autoimmune models. In new experiments concerning the induced auto-antibody response to acetylcholine receptor (AChR), which causes an experimental myasthenia gravis-like condition, androgen administration reduces the level of auto-antibodies about 70%. As confirmation, earlier experiments demonstrated that male NZB/NZW mice developed the early autoimmune disease pattern of the female NZB/NZW mice if they were castrated prior to puberty. In summary, sex hormones affect immunity by acting on the thymus, spleen and reticuloendothelial system.

Immunomodulation and Immunorestoration

What are the prospects for immunomodulation and immunorestoration in relation to stress and disease? Intensive research on the immune system has revealed possible mechanisms that underlie the immune response and its regulation by focusing on cellular and molecular levels governing cell-mediated and humoral immune responses both *in vitro* and *in vivo*. The *in vitro* approach has made it possible to dissect the various cellular compartments and to identify cell products, enabling investigators to examine specific questions using well-defined experimental conditions. Second, findings emanating from *in vitro* analyses usually have been confirmed *in vivo*, even though *in vivo* studies pose serious problems due to complex interactions within the immune system and between it and other systems. Lymphoid organs and the hematopoietic system are under both direct and indirect influences of the central nervous system, as revealed, for example, by nerve endings found in the bone marrow and lymphoid organs, a condition known to exist in more primitive animals such as frogs.[11] If we can understand how the nervous system influences immune responses, we should be able to modulate the immune response at will by studies of neuroimmunomodulation as an independent discipline. Three main mechanisms have been implicated for this field, namely circulatory, direct pathway and feedback.

One theory deals with how the thymus gland influences the immune response through the effect of thymosin peptides and how they, in turn, are influenced by the central nervous system. By a feedback regulatory mechanism, thymosin peptides act on the central nervous system to modulate hormones that, in turn, influence and regulate the immune system. (Figure 4) Several thymosin peptides have been isolated and characterized chemically. Their effect on the immune response was examined extensively. Individual peptides exert effects selectively at different stages of thymocyte differentiation. Thymic peptides induce the precursor pre-T cells to mature. Mature T cells then circulate and mediate various immunological functions, such as delayed hypersensitivity, regulation, helper function, cytotoxicity, etc. Likewise, thymosin triggers the hypothalamic pituitary axis into releasing corticosteroids which can influence the immune response.

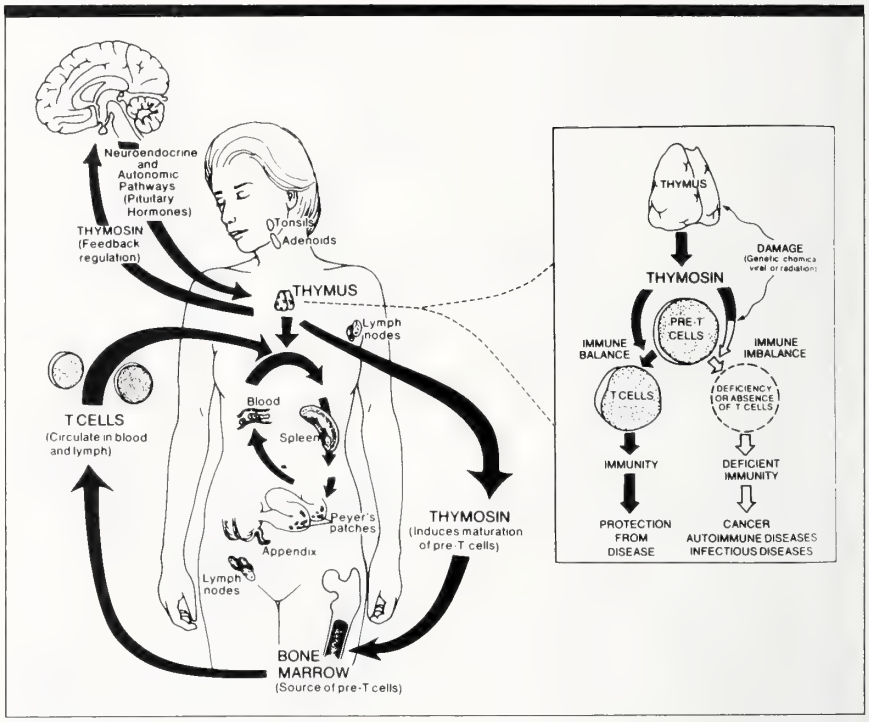


Figure 4
Organization of the thymus-dependent immune system illustrating the proposed interrelationships with the nervous and endocrine systems.

Lymphocytes, macrophages and granulocytes bear receptors for neurotransmitters, hormones and inflammatory mediators and can therefore be regulated by these stimuli. Five mechanisms have been postulated by which various mediators affect cellular functions. These include cyclic AMP, cyclic GMP,

ATPase, nuclear acceptors and calcium regulation. There is a role of cyclic nucleotides and, in particular, the central one played by Ca++ dependent release of arachidonic acid and its conversion to PG3 by the cyclo-oxygenase pathways, causing negative feedback mechanisms via cyclic AMP. In contrast, conversion of arachidonic acid to its metabolites by the lypoxygenase system is implicated in positive activating mechanisms via cyclic GMP. There is complexity when considering how these various stimuli can influence lymphocytes, since there are multiple effects by other mediators exerted simultaneously on the same cell or related cells. Nevertheless, research should continue into the role of various immunomodulating agents in controlling immune responses. For example, there is new information suggesting that the enkephalins stimulate the immune system in times of stress. Early results reveal the enhancement of active T cell rosettes by enkephalins as a necessary increase in certain cell-mediated immune reactions in response to stress. In another direction, with respect to suppressing senescence, administration of the drug isoprinosine, a chemical immune potentiator, has been shown to reverse certain characteristics of senescence. For example, old hamsters treated with weekly injections of isoprinosine showed the levels of response typical of young adults as measured by four immunological assays, namely natural killer cells, T cells, monocytes and suppressor cells.

Senescence Immunodeficiency

Can immunodeficiency arising from senescence and stress be treated by immunorestoration? Just as stress can bring about changes in the immune system, so can senescence produce similar, dramatic changes. The major changes in old age relate predominantly to the function of T-lymphocytes and can be direct and indirect by affecting antibody production insofar as it is regulated by T cells. Most specifically, T cell proliferative responses to mitogens, alloantigens and conventional antigens decline with age. In addition, mixed lymphocyte reactions (MLR), cytotoxic T cell (CTL) and graft-vs.-host (GVH) decline with age, to cite the most obvious examples.

With respect to B cells, there seems to be conflicting evidence on whether the numbers and proportions change in old age. However, there is a general consensus that serum-immunoglobulin components, as well as their specificities, do show age-related changes, one of which is worth mentioning. The defects in humoral immunity associated with old age—increased autoantibodies, auto-anti-idiotypic antibodies and monoclonal antibodies—all seem related to defective T cell collaboration and/or regulation of B cell function. In contrast to T- and B-lymphocyte alterations, macrophage numbers and antigen-processing capacity seem to indicate no major changes with age. The MHC, a cluster of genes found probably in all vertebrates, controls a great many immune functions, and in this sense provides an important link between lifespan, aging, disease and the immune system. One final point worth a great deal of emphasis is the compelling evidence revealing that dietary restriction imposed experimentally will result in significantly longer life span and improved immune responses.[12]

Concerning immunorestoration, there are beneficial and potential uses of various agents in clinical immunotherapy for patients who have been immunosuppressed as a result of aging or stress. For example, animal experiments using thymosin fraction V or equivalent extracts have been employed to treat both primary and secondary immune deficiencies. Lymphokines have also been used, most notably interferon in cancer treatment and viral infections. In addition, chemically-defined agents such as levamisole and isoprinosine have been shown to augment the immune response. Presently, immunopharmacology has become a science of the present and the future, aimed at characterizing agents that have selective effects on particular functions of the system in our quest for immunorestoration.

Summary

Our daily lives are filled with stress-producing situations which affect our immune systems at the cellular level. Stories about fatigue leading to lowered resistance and the decline of youth-producing disease are probably not all hearsay. We are susceptible to those ills, perhaps psychosomatic, perhaps organic, which may result from bombarding the interconnected immune and neuroendocrine systems by unpleasant stimuli, such as noise, and which produce damaging and perhaps long-term changes to the body and to the spirit. As revealed in this review, lowered resistance and environmental pressures can lead to alterations in the body's immuno/defense system. No longer just hearsay, due to mounting experimental data, there should be enough encouragement to foster exchange between leading authorities in neuroendocrinology, immunology and aging to close the gap between speculation and interpretations derived from the repeatable results of well-designed experiments. The immune and neuroendocrine systems can affect each other, but that they interconnect is an important challenge that can lead us to modify either system if need be, to produce beneficial, not harmful, results. ◀

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Acknowledgements

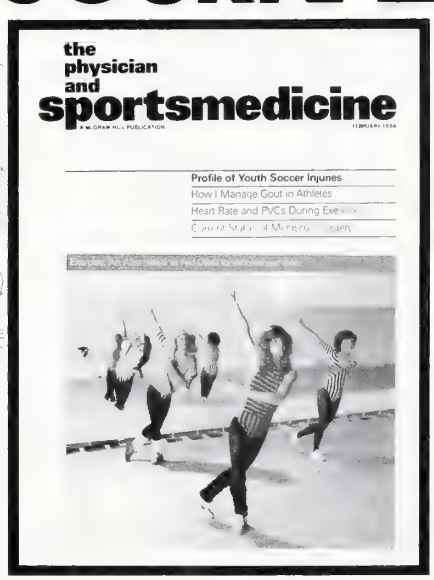
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External Neutron Beam Therapy

By Lionel Cohen, M.D., Ph.D. and Frank R. Hendrickson, M.D./Batavia

Local control of non-resectable cancer by irradiation frequently fails, owing to a relative radioresistance of the tumor. Radioresistance of tumor cells is attributed to the capacity of many cells to sustain and repair radiation damage to critical target molecules, oxygen-deficient regions within the tumor and variation in radiosensitivity at different phases of the cell division cycle. These biological mechanisms are associated with low-LET radiation. They are much less evident with heavily ionizing or high-LET radiation, which apparently induces irreparable changes in chromosome structure independently of cellular metabolism or biochemical state. For this reason, tumors resistant to conventional radiotherapy are expected to prove relatively responsive to high-LET radiation.

Approximately 10,000 patients have been studied in 20 neutron therapy centers in the United States, Europe and Japan. Not all tumors studied for the new modality have shown significant advantages clinically and statistically. However, striking results have been demonstrated in relatively radioresistant, locally advanced, non-metastatic tumors. These include late stage epidermoid cancer, non-epidermoid cancer of the head and neck, salivary gland tumors, carcinomas of bladder, prostate and sigmoid colon, sarcomas of bone and soft tissue, and melanoma. Pilot studies of brain, lung and pancreatic tumors suggest promising new approaches to management of cancer in these sites.

Neutrons expand the scope of radiation therapy to include intrinsically radioresistant tumors. They simplify treatment logistics by reducing the need for protracted courses, permit use of conservative or corrective surgery in patients following tumor ablation by radiation, expand the role of elective chemotherapy for prevention of metastases in locally controlled patients and provide new options for patients who may wish to avoid extensive surgery.

The availability of high energy neutron beams in the clinical environment provides the practicing radiation oncologist with the unique capability of solving problems relating to radioresistance, dose, time, fractionation and optimization. Many radiobiological mechanisms which influence tissue response to conventional (low-LET) radiation become insignificant with high-LET beams. These mechanisms include repair of sublethal and potentially lethal damage, variation in cellular radiosensitivity at different phases of the cell division cycle and tumor radioresistance associated with hypoxia. In conventional radiotherapeutic practice these problems are partially resolved by low dose-rate continuous irradiation, hyperfractionation or accelerated fractionation. The advantages of these maneuvers can be achieved without the associated logistical problems by using high-LET beams.

The major significant variates of neutrons are total dose delivered and overall time. When the appropriate dosage and times have been chosen, treatments can be implemented without constraints on fraction size and number. Because of this, neutrons could be useful: (1) for tumors with rapidly repopulating cells in which short treatment times are advantageous (epidermoid carcinomas); (2) in tumors with a high capacity to sustain and repair radiation damage (sarcoma, melanoma); (3) in slowly cycling tumors with a corresponding capacity to repair potentially lethal damage (salivary tumors, prostate) and (4) in large hypoxic tumors.

Most of the logistic problems associated with optimal fractionation for relatively resistant tumors

become irrelevant with neutron irradiation. A simple four to five week schedule with two or three fractions/week has proved suitable for neutron beam therapy in most clinical situations. By 1986 neutron beam therapy was available in 26 radiotherapy centers throughout the world. (Table 1)

Table 1
Neutron Therapy Facilities—1985

United States	Cleveland	GLANTA
	* Chicago	Fermilab
	Chicago (University)	D-D
	* Houston	TAMVEC, MDAH
	* Los Angeles	UCLA
	Philadelphia	D-T
	* Seattle	University of Washington
	# Washington D.C.	MANTA
Europe	# Amsterdam (D-T)	Holland
	Dresden	Germany-DDR
	Edinburgh	UK
	Essen	Germany
	Gent	Belgium
	Hamburg (D-T)	Germany
	Hammersmith	UK
	Heidelberg (D-T)	Germany
	Krakow	Poland
	* Liverpool	UK
	* Louvaine	Belgium
	# Manchester (D-T)	UK
	Orleans	France
Other	* Cape Town	South Africa
	Chiba-shi (NIRS)	Japan
	Pretoria	South Africa
	Riyadh	Saudi Arabia
	Tokyo (IMS)	Japan

** = High-energy (p-Be) units*
= Facility closed

Clinical Results

Head and Neck

Use of neutron beams in cancer management has been a hotly-debated issue since first reports from Hammersmith Hospital in London indicated a marked superiority in local control of neutron-treated late stage (T3 and T4, N0-2, M0) carcinomas of the head and neck compared with conventionally treated controls.[1] However, the sharp difference in response rates (76% with neutrons, 19% photon controls) could not be confirmed by other workers,[2] who reported only marginal improvement with neutrons. A typical report by the EORTC (European Organization for Research on Treatment of Cancer) shows, in a random study, 48% local control with neutrons compared with 43% with photons, a difference which is not statistically significant. A summary of European and American experience with neutrons, photons and various combinations of the two modalities in the management of locally advanced epidermoid carcinoma of the head and neck is shown in Table 2.

Pooling data from the four centers listed yields an overall local control rate of 49 (± 3)% with neutrons and 38 (± 3)% with the photon controls. If the controversial Hammersmith data are excluded, the corresponding rates are 47 (± 3)% for neutrons compared with 44 (± 3)% for photons. This difference is marginally significant statistically, and probably represents a real, though small, clinical gain.

The relative value of neutron versus standard radiation therapy was not influenced by the site of origin of the tumor or the T-stage of the disease.[3] Also, no obvious advantage was seen in mixed modality (photons plus neutrons) procedures. However, a study of mixed-beam versus photon irradiation for large non-resectable lymph nodes in head and neck cancer showed significant improvement in local control for the neutron-treated patients.[4]

Histology had a marked effect on the response. (Table 3) In the Fermilab series, non-epidermoid carcinomas, including tumors of major salivary glands, salivary type tumors in ectopic sites and adenocarcinomas, were shown to be markedly more responsive to neutrons (70% local control) than were epidermoid carcinomas (36% local control).[3] This is remarkable, since it is generally believed that non-epidermoid tumors are relatively radioresistant. Local control rates for unresected salivary gland tumors are under 40%, even with maximally-tolerated doses of photon irradiation.[5]

It can be concluded, at least in regard to head and neck cancer, that neutron beam therapy is a useful addition to the armamentarium of the oncologist in the management of non-resectable metastatic lymph nodes in the neck, when the primary has been controlled and distant metastases are not in evidence and, also, for most non-epidermoid carcinomas. Neutron beam therapy may indeed be the treatment of choice in non-resectable non-epidermoid carcinomas of the head and neck.[3]

Sarcoma of Bone and Soft Tissue

These tumors generally have been classified as radioresistant. They are treated primarily with surgery and adjuvant radiotherapy and/or chemotherapy. In the case of bone sarcoma, situations arise where the tumor cannot be resected

Table 2
Local Control in Epidermoid Carcinoma of the Head and Neck
(As of February 1982)

	Photons				Neutrons			
	Treated	Contr.	Compl.	PUC*	Treated	Contr.	Compl.	PUC*
Hammersmith [1]	63	12 (19%)	3 (5%)	18%	70	53 (76%)	12 (17%)	63%
EORTC**[14]	95	41 (43%)	8 (8%)	40%	100	48 (48%)	16 (16%)	40%
Houston[15]	41	18 (44%)	3 (7%)	41%	49	3 (6%)	10 (20%)	5%
Fermilab[3]	73	32 (44%)	4 (5%)	42%	51	28 (55%)	11 (22%)	43%
TOTAL	272	103 (38%)	18 (7%)	35%	270	132 (49%)	49 (37%)	31%

**PUC (Percent Uncompl. Contr.) = (Control Rate) × (1-Complication Rate).*
***EORTC—European Organization for Research and Treatment of Cancer.*

because of its anatomic location (*i.e.*, in the axial skeleton) or patients who refuse surgery. It has been shown that neutrons offer a viable alternative to surgical ablation in these cases. The response of chondrosarcoma is markedly better than that of osteogenic sarcomas. (Table 4) As shown in Table 5, which is based upon experience in Europe, Japan and the United States, 59% of such nonresectable bone sarcomas have been locally controlled. Long term survival rates apparently were not significantly different from those observed after surgical ablation of the growth.

Soft tissue sarcoma management generally entails resection and postoperative irradiation.[6] When the disease is unresectable for any reason, neutrons have been shown to offer a reasonable, alternative form of management. European studies have provided a wide experience; smaller numbers of patients have been treated in the United States and Japan. The local control rate for soft tissue sarcoma appears to be higher with neutrons (62%) than with conventional radiotherapy, at least in unresectable cases. The overall survival rate is commensurate with that obtained in patients undergoing surgical resection of the tumor in comparable stages.

The value of neutron beam therapy in sarcomas of bone and soft tissue is that this treatment offers a fair prospect of local control even in those situations where the tumor cannot be resected.

Melanoma

Melanomas are reputed to be radioresistant, since they seldom respond to low-LET radiation in conventional dosage and fractionation. This radioresistance has been variously attributed to an exceptional capacity to sustain and repair sublethal damage, the ability of melanoma cells to repair potentially lethal damage and virtual hypoxia due to radical scavenging properties of melanin and its precursors. These factors can be overcome by using exceptionally high doses of radiation, but unless the treatment volume is small, this has an excessively high risk of injury to normal tissue. To some extent the effect of a high capacity to repair sublethal damage can be overcome by such unconventional fractionation as delivering relatively large doses in a small number of fractions at intervals of a week or more. This approach has reportedly been successful in ablating the tumor in many patients, but still carries a substantial risk of severe late effects. However, radiobiological studies have shown that any or all of the factors believed to contribute to the radioresistance of melanoma can be overcome by the use of high-LET irradiation.

Accordingly, a trial use of neu-

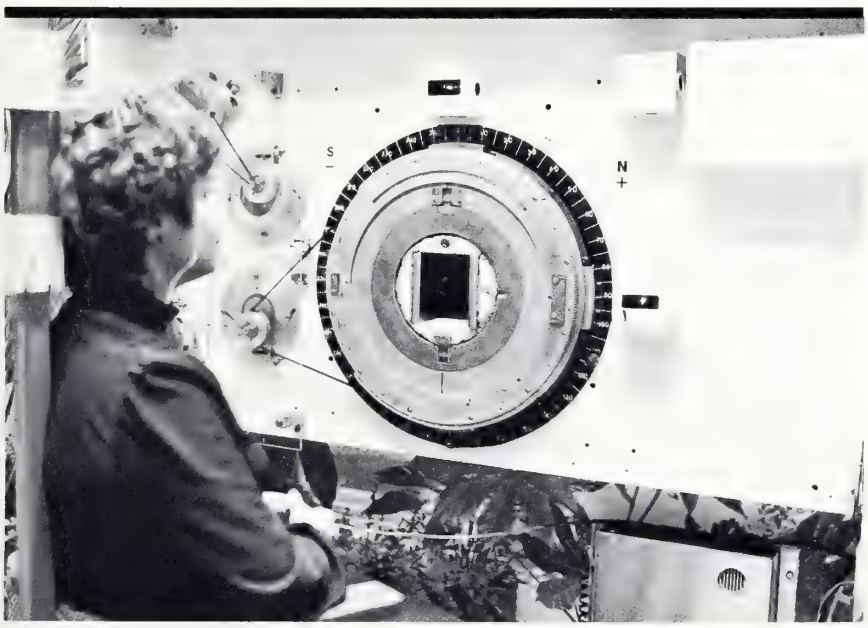


Figure 1
Patient seated in the treatment chair. The neutron beam aperture (in center of photo) can be turned via a remote control. (Reprinted with permission of Fermilab photography department, Fermi National Accelerator Laboratory, Batavia, Illinois.)

Table 3
Head and Neck Carcinoma: Local Control Versus Site and Histology[3]

Site	Epidermoid	Non-Epidermoid	Total
Oral cavity	3/18	6/7	9/25
Oropharynx	6/16	3/5	9/21
Larynx	5/8	—	5/8
Hypopharynx	5/7	—	5/7
Nasopharynx	0/1	0/1	0/2
Paranasal	1/3	3/6	4/9
Prim. unknown	0/3	3/3	3/6
Maj. salivary glands	—	18/25	18/25
TOTAL	20/56 (36%)	33/47 (70%)	53/103 (51%)

tron beam therapy for the treatment of non-resectable melanomas is being advocated. Results from Chiba (Japan) and Fermilab indicate that a substantial proportion of melanomas irradiated with moderate doses of neutrons (generally 16-20Gy) are locally controlled. Local control rates average near 71%. (Table 5) This type of response has been exceptionally gratifying in melanomas around the face and neck, in which the only alternative would have been very extensive and disfiguring surgery.

Adenocarcinoma of the GI Tract

In view of the good response of non-epidermoid cancers of the head and neck to neutrons, two other sites were deemed worthy of investigation: carcinoma of the pancreas and carcinoma of the rectosigmoid. Over 90 patients with adenocarcinoma of the pancreas have been treated with neutrons at our institution.[7] The overall survival rate is not superior to that of conventional radiotherapy.[8] However, the pattern of failure appears to be different. When post-irradiation histology could be evaluated following second-look surgery or at autopsy,[9] the neutron-irradiated pancreatic tumors showed a marked local response in the majority of patients. There was massive fibrosis of the pancreas and tumor site, with no more than microscopic residual foci of cancer. In the autopsied series, death was usually attributed to metastatic dissemination rather than local failure. This contrasts with other series, where persistent local tumor has been a major contributing factor to the fatal outcome.[10] Studies combining neutron irradiation for local control and systemic chemotherapy for the inhibition of metastatic dissemination are currently underway.

Unresectable or recurrent cancer of the rectosigmoid is seldom, if ever, amenable to curative radiotherapy, since the doses required to achieve a high probability of tumor regression are usually beyond the tolerance limits of adjacent normal bowel. In view of the relative sensitivity of adenocarcinomas in other sites, neutrons would seem to be a reasonable choice for the treatment of cancer under these circumstances.

Only one study has been undertaken in this area, in which 25 patients with advanced unresectable cancer of the rectosigmoid colon were irradiated using a relatively low energy neutron beam.[11] This beam was physically unsuited for pelvic irradiation because of poor penetration associated with its relatively low energy and consequent risk of overdosing adjacent or overlying structures. Nevertheless, 13 of 25 (52%) patients treated were locally controlled. (Table 5) It may be reasonable to conclude that neutrons could be a useful modality in rectosigmoid cancers which are nonresectable from the start, show gross residual disease following attempted surgery, have recurred following surgery, or have arisen in patients who are medically or psychologically unfit for rectal surgery.

Table 4
Neutron Response of Sarcoma of Bone and Soft-Tissue[19]

		Size		Site			Results	
Pathology	Number	>5cm	<5cm	Head	Trunk	Limb	Alive (%)	Control (%)
Bone								
Osteosarcoma	9	3	6	4	4	1	1 (11)	2 (22)
Chondrosarcoma	16	9	7	6	9	1	9 (56)	9 (56)
TOTAL	25	12	13	10	13	2	10 (40)	11 (44)
Soft-Tissue								
Liposarcoma	7	2	5	1	4	2	4 (57)	5 (71)
Fibrosarcoma	8	4	4	1	5	2	1 (13)	3 (38)
Leiomyosarcoma	5	3	2	1	4	0	0 (0)	1 (20)
Schwannoma	3	0	3	0	1	2	3 (100)	3 (100)
Synovioma	3	2	1	0	1	2	0 (0)	1 (33)
TOTAL	26	11	15	3	15	8	8 (31)	13 (50)
All Sarcomas	51	23	28	13	28	10	18 (35)	24 (47)

Table 5
Long-Term Control in Non-Resectable Radioresistant Tumors Treated By Neutrons
(International Experience, Dec. 1982)

Tumor Type	Facility	Treated	Controlled
Salivary Tumors	Hammersmith	40	30
	Amsterdam	30	22
	Seattle	11	7
	RTOG	31	25
	Fermilab	39	28
	TOTAL	151	112 (74%)
Sarcoma of Bone	MANTA	7	6
	CHIBA (Japan)	18	15
	Essen	24	12
	Fermilab	25	11
	TOTAL	74	44 (59%)
Soft Tissue Sarcoma	Houston	29	20
	MANTA	7	4
	CHIBA	12	7
	EORTC (Europe)	189	108
	Fermilab	26	13
	TOTAL	263	152 (58%)
Melanoma	CHIBA	14	12
	Fermilab	7	3
	TOTAL	21	15 (71%)
Rectosigmoid Cancer	Amsterdam	25	13 (52%)
Bladder Cancer	Amsterdam	22	10
	Fermilab	8	5
	TOTAL	30	15 (50%)

Bladder Cancer

There is still considerable debate as to whether primarily resectable bladder cancer should be treated by preoperative radiation followed by cystectomy or by primary irradiation with cystectomy salvage.[12,13] Primary irradiation therapy has been advocated for non-resectable (stages C and D) carcinomas of the bladder. In these late stage cancers, a worthwhile response is usually obtained, but long term control is relatively infrequent. Studies of neutron beam irradiation for this condition have been carried out at Amsterdam[11] and at Fermilab. At the present time the combined statistics from these two centers show that the long term local control rate for neutron beam irradiation of advanced bladder cancer exceeds 50%. (Table 5) It is noteworthy that in the majority of these patients normal urinary continence and sexual function have been retained.

Brain Tumor

Primary tumors of the brain are relatively radioresistant. In particular, the high grade glioma, glioblastoma multiforme, has an exceptionally poor prognosis, in that, it is seldom controlled by surgery and not ablated by conventional radiotherapy. The initial trial of neutron beam therapy for high grade gliomas in Hammersmith[1] showed that neutron therapy in doses of 16Gy in 12 fractions over four weeks apparently succeeded in destroying the tumor in most cases, but did not prolong life beyond that achieved with conventional radiation. Autopsy studies in this series showed that the common cause of death was radiation encephalopathy. Subsequent studies with lower doses[16] designed to minimize the risk of brain necrosis, failed to show any improvement in survival; all patients died of persistent or recurrent tumor.

It had also been suggested that there might be some advantage in accelerated courses of radiotherapy for brain tumors on the grounds that the cellular proliferation rate of the tumor was likely to be much greater than that of normal brain cells. This is in contrast to tumors arising in many other tissues. Accelerated fractionation is logistically difficult with photons. Fraction size must necessarily be kept small in order to minimize the risk of brain damage, while total doses need to be large. These requirements are only partially met by using two or three fractions per day, instead of conventional fractionation.

With neutrons, on the other hand, fraction size is irrelevant, and treatment can be accelerated simply by reducing the number of fractions and/or the interval between fractions. At our institution it has been noted that 18Gy can be delivered to the target volume in six fractions without any untoward acute reactions. Current studies entail delivery of the required dose (18Gy) in six fractions over two weeks (three times weekly). Thus, neutron therapy permits accelerated treatment to a degree unobtainable with low-LET radiation. It is still too early to evaluate tumor response or survival.

Conclusions

Neutrons may not be a superior form of radiotherapy in all situations. However, they do have significant advantages in certain specific sites, six of which are listed in the accompanying table based on international experience. (Table 5) All of these tumors are reputedly resistant to conventional irradiation, and are generally treated by surgical resection when feasible. The results shown in the table are based on inoperable and unresectable locally advanced tumors without overt metastases. These patients would normally have been expected to succumb to uncontrolled local extension of the disease. The majority of patients so treated (between 50%-75%) have been controlled by neutron beam irradiation. It is con-

cluded that neutrons provide a useful modality in the management of unresectable radioresistant tumors, particularly sarcomas of the musculoskeletal system and adenocarcinomas in various sites.

The new modality is likely to have considerable impact on the practice of clinical oncology with respect to the following five considerations:

- The use of neutrons can expand the scope of radiation therapy to include intrinsically radioresistant tumors formerly considered unsuitable for irradiation;
- In areas where tumor ablation can be accomplished by irradiation alone, new procedures for conservative or corrective surgery become feasible;
- With improved control of local disease, neutrons expand the role of elective chemotherapy for the prevention or retardation of metastatic growth;
- Neutrons expand the range of options available to cancer patients who may wish to consider conservative treatment with the new modality as a possible alternative to radical surgery, and
- The feasibility of reduced fractionation (12 fractions instead of the 30-40 required in conventional radiation therapy) has important economic gains. This logistic advantage, together with some improvement in control rates and no additional morbidity, may prove neutron beams to be the most cost-effective option in providing long-term control of curable cancer. Costs of neutron irradiation at our institution are comparable to conventional radiotherapy and are covered by most insurance carriers. ◀

References

A complete list of references to "External Neutron Beam Therapy" may be obtained by writing the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

Frank R. Hendrickson, M.D., a board certified radiologist, is chairman of the department of therapeutic radiology at Rush-Presbyterian-St. Luke's Medical Center, Chicago, and professor of therapeutic radiology, Rush Medical College. Dr. Hendrickson is director of the Neutron Therapy Facility, Fermi National Accelerator Laboratory, Batavia. He is a past president of the Illinois Cancer Council, the Illinois Comprehensive Cancer Center and the American Cancer Society's Illinois Division. Dr. Hendrickson has served as board director of the Illinois Comprehensive Cancer Center, is a past chairman of the Commission on Radiation Therapy of the American College of Radiology and is a past chairman of the board of the American Society of Therapeutic Radiologists. He is a diplomate of the American Board of Radiology, and a member of the American College of Radiology and the American Society of Clinical Oncology.

Lionel Cohen, M.D., Ph.D., is co-director of the Neutron Therapy Facility, Fermilab National Accelerator Laboratory, Batavia, and director of the department of radiation oncology, Michael Reese Medical Center, Chicago. Dr. Cohen is a professor in the department of radiology at the University of Chicago. He is a member of the British Institute of Radiology, the Radiation Research Society, the Radiological Society of North America, and the American College of Radiology.

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OBITUARIES

***Abromaitis, Gerhard,** Crystal Lake, died January 6, 1987 at the age of 67. Dr. Abromaitis was a 1949 graduate of the Medizinische Fakultat der Phillipps-Universitat, Marburg/Lahn, Hessen, Germany.

***Burton, Jonathan,** Chicago, died January 31, 1987 at the age of 62. Dr. Burton was a 1956 graduate of Northwestern University Medical School, Chicago.

****Changnon, Eugene,** Tinley Park, died February 6, 1987 at the age of 82. Dr. Changnon was a 1935 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

***DeKovessey, Charles A.,** Olney, died January 24, 1987 at the age of 68. Dr. DeKovessey was a 1946 graduate of the New York University School of Medicine, New York.

****Esau, J. Nick,** Palos Hills, died January 27, 1987 at the age of 83. Dr. Esau was a 1932 graduate of Rush Medical College, Chicago.

Jacula, Stephen, Burr Ridge, died January 29, 1987 at the age of 71. Dr. Jacula was a 1953 graduate of the University of Illinois College of Medicine, Chicago.

***Method, Harold L.,** Chicago, died February 16, 1987 at the age of 68. Dr. Method was a 1944 graduate of Northwestern University Medical School, Chicago.

***Mijanovich, Mladen,** Marengo, died February 6, 1987 at the age of 66. Dr. Mijanovich was a 1949 graduate of the University of Illinois College of Medicine, Chicago.

****Miller, Herbert P.,** Rock Island, died February 20, 1987 at the age of 92. Dr. Miller was a 1921 graduate of the University of Iowa College of Medicine, Iowa City.

Raich, John A., Carbondale, died January 24, 1987 at the age of 85. Dr. Raich was a 1927 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

***Rold, Dale A.,** Carlsbad, California, died October 23, 1986 at the age of 75. Dr. Rold was a 1938 graduate of the University of Iowa College of Medicine, Iowa City.

***Rutter, Captola,** Baltimore, Maryland, died January 10, 1987 at the age of 83. Dr. Rutter was a 1929 graduate of the Baylor College of Medicine, Houston, Texas.

****Ungar, Jacob,** Oak Park, died February 15, 1987 at the age of 83. Dr. Ungar was a 1930 graduate of the Facolta di Medicina e Chiurgia dell' Universita di Modena, Modena, Italy.

***Walker, Maggie L.,** Chicago, died December 17, 1986 at the age of 68. Dr. Walker was a 1941 graduate of the University of Michigan Medical School, Ann Arbor, Michigan.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Elder Abuse: The Physician's Role in Identification and Prevention

By Carolyn Cochran and Sally Petrone/Springfield

Physicians should constitute the "front line" in discovering and offering help for the elderly who are abused or neglected. Yet, preliminary data from an Illinois demonstration project to ferret out elder abuse show that doctors have not reported abuse in large numbers. This is despite national estimates approximating 10% of Americans over age 65 are abused. The following article contains practical information to help physicians find out about and halt abuses suffered by the elderly.

Elder abuse is receiving increased attention across the country as information about its existence emerges. Over the past 10 years, many states passed legislation mandating the reporting of suspected cases of elder abuse without first investigating its potential impact on either the victims or the service delivery system.

The State of Illinois took a unique approach to developing legislation to assist elder abuse victims. Instead of rushing to pass mandatory reporting legislation, the State of Illinois decided to first gather critical information about the extent, cost and effectiveness of providing help for community elderly who are victims of abuse, neglect and/or exploitation. For three years, the state legislature funded four elder abuse demonstration projects with the purpose of developing statewide elder abuse legislation only after analyzing the results from the evaluation of these projects.

The Illinois State Legislature passed two pieces of legislation creating the Elder Abuse Demonstration Program Act during the Spring Session of 1984. This Act will continue until June 30, 1987.

Demonstration project sites are Winnebago County (Rockford); Kankakee County; Niles, Maine and Evanston Townships in suburban Cook County; and Franklin, Williamson, Jackson and Perry Counties (Egyptian Area). In these areas, the Illinois Department on Aging encouraged, and even mandated in one instance, the reporting of elder abuse. A variety of sources—physicians, family members, social service agencies and others—were targeted as possible sources of elder abuse reports.

Preliminary data on elder abuse accompany this article. Final results will be forthcoming from the Illinois Department on Aging when the demonstration project ends on June 30, 1987. The Department has drafted legislation to extend that deadline by three months.

In addition, all other areas of the state have Area Agencies on Aging to respond on an ad hoc basis to reported cases of abuse and neglect.

The Elder Abuse Demonstration Program Act grants immunity in the project sites from civil liability to any person, institution or agency, who, in good faith, reports suspected elder abuse, participates in the investigation, or takes photographs or x-rays. This Act was amended recently to grant immunity for the entire State of Illinois. Since the medical community is in contact with older persons, this article will inform physicians about the problem of elder abuse, how to identify and prevent elder abuse, and what is being done in Illinois.

The Problem

Data suggest that elder abuse, referred to as the "hidden problem," occurs at a rate only slightly less than child abuse. It has been indicated by various studies that one out of three child abuse cases is reported, but only one out of six elder abuse cases come to the atten-

tion of authorities. In 1981, the House Select Committee on Aging concluded that four percent of the nation's elderly may be victims of some sort of abuse. Estimates of the number of elderly persons abused each year in our country range from 500,000 to 2.5 million.

In Illinois, a 1981 Sangamon State University study estimated that at least four percent (47,000) of older Illinois residents would be reported as abused annually.

Identification and Treatment

Proper identification is the first step in assisting elderly victims. Research, program planning and intervention all depend on service providers in various fields identifying and referring abused elders. Most authorities agree that victims of domestic violence are overlooked by physicians. Social service workers report that they often do not learn of an abusive situation until after they have known the client for several months. An estimated 92% of the clients assessed/investigated by the Illinois Elder Abuse Demonstration Program were new to the Aging Network, meaning these individuals would not have been assisted or contacted if it had not been for the Demonstration Program. Such delays cause abused elders to endure considerable pain—which could have been avoided if abuse were identified earlier.

Table 1
Classification of Types of Elder Abuse

Physical or Sexual Abuse

- Bruises (bilateral and at different stages of healing)
- Welts
- Lacerations
- Punctures
- Fractures
- Evidence of excessive drugging
- Burns
- Physical constraints (tying to beds, etc.)
- Malnutrition and/or dehydration
- Lack of personal care
- Inadequate heating
- Lack of food and water
- Unclean clothes or bedding
- Lack of needed medication
- Lack of eyeglasses, hearing aids, false teeth
- Difficulty in walking or sitting
- Venereal disease
- Pain or itching, bruises, or bleeding of external genitalia, vaginal area, or anal area

Neglect

- Conduct of vulnerable adult or others that results in deprivation of care necessary to maintain physical and mental health
- May be manifested by:
  - Malnutrition
  - Poor personal hygiene
  - Any of the indicators for medical abuse

Psychological Abuse (vulnerable adults react by exhibiting resignation, fear, depression, mental confusion, anger, ambivalence, insomnia)

- Threats
- Insults
- Harassment
- Withholding of security and affection
- Harsh orders
- Refusal on the part of the family or those caring for the adult to allow travel, visits by friends or other family members, attendance at church

Exploitation

- Misuse of vulnerable adult's income or other financial resources (victim is best source of information, but in most cases has turned management of financial affairs over to another person; as a result, there may be some confusion about finances)

Medical Abuse

- Withholding or improper administration of medications or necessary medical treatments for a condition, or the withholding of aids the person would medically require such as false teeth, glasses, hearing aids
- May be a cause of:
  - Confusion
  - Disorientation
  - Memory impairment
  - Agitation
  - Lethargy
  - Self-neglect

(Reprinted with permission of the Washington State Medical Association)

Reporting Elder Abuse

1-800-252-8966 is the Illinois Department on Aging's hotline number for reporting elder abuse and neglect. The hotline is open Monday through Friday, 8:30 a.m.-5:00 p.m. All calls are confidential. The number can also be used to inquire about services for the aging.

In responding to calls, hotline staff refer specific cases to locally-based representatives of the Department on Aging. An investigation then begins.

The above phone number should *not* be used to complain about health care institutions or nursing homes. The Illinois Department of Public Health (IDPH) oversees nursing homes and investigates allegations of impropriety there. The IDPH hotline number is 1-800-252-4343. Again, calls are confidential.

AMA Calls for Measures to Halt Abuse of the Elderly

As many as 10 percent of America's elderly may suffer from some type of abuse, and four percent of those over 65 years of age may experience moderate to severe abuse, according to an AMA Council on Scientific Affairs report appearing in the February 20, 1987 *Journal of the American Medical Association.*

The report, adopted by the AMA House of Delegates at its Annual Meeting in June, 1986, found that "one in every 25 elderly Americans may be victims of such abuse, representing an increase of approximately 100,000 abuse cases annually since 1981." The abuse takes many forms, including: passive neglect, emotional and verbal abuse, malicious withholding of required services, and financial exploitation. A detailed list provided in the report enumerates and categorizes types of abuse. This list, originally developed by the Washington State Medical Association, can be found on page 242 of *IMJ.*

In comparing elder abuse to abuse of children, the report notes, "While the states spend an average of $22 per child for protective services, only $2.90 is spent for each elderly person." The incidence of abuse of the elderly is only slightly less prevalent than child abuse, yet while one-third of child abuse incidents are reported, only one-fifth of the incidents involving the elderly are reported. The average state spends 4.7 percent of its budget on protective services for the elderly, although as many as 40 percent of abuse cases involve adults and the elderly.

Physicians involved in treatment of patients who suffer elder abuse are advised to address several objectives. These include: identifying those who may have been abused; instituting steps to prevent additional injury; evaluating and treating injuries sustained through abuse; maintaining objectivity and not being judgmental; establishing continuity of a therapeutic alliance with family members; and complying with all state statutes for reporting suspected abuse. The Council's report reminds physicians to make use of existing community resources that provide respite care, in-home services and stress reduction.

Calling elder abuse "a complex problem with dynamic and variable origins," the report suggests a multidisciplinary approach to case management. Teams of physicians, nurses, social workers, psychologists, psychiatrists, attorneys and others working with a team leader should be responsible for working toward specific goals. "These goals," according to the report, "may include coordination, diagnosis or identification, prevention, treatment, consultation and education."

The Council report includes the following recommendations:

- The AMA initiate the establishment of a multidisciplinary task force to develop approaches to intervention and prevention of elder abuse, and to coordinate mutually supportive activities of various constituencies (*e.g.,* American Association of Retired Persons, American Nurses Association, American Public Health Association, American Hospital Association).
- Diagnostic and treatment guidelines concerning elder abuse and neglect be developed from the information contained in this report.
- The AMA organize a programmatic effort to address the national concern of elder abuse through state medical societies.

Illinois is represented on the AMA's Council on Scientific Affairs by Joseph Skom, M.D. ◂

Physicians and other medical professionals can play a key role in the identification of elder abuse. For some elders, a physician is the only professional—possibly the only person—they may see and trust. Because of their role, physicians are in a position to thoroughly examine elders and to question them and their families or caretakers about symptoms or injuries. It provides an opportune moment for intervention and could break the "cycle of violence." To be a valuable link in efforts to combat elder abuse, it is crucial that physicians be able to identify elder abuse, know where to refer abused elders and be aware of and involved in developing programs and laws.

The following guidelines are designed to help you respond to the complex problems of elder abuse victims: to diagnose and treat patients' physical injuries; to evaluate victims' strengths and deficiencies; to determine what actions

Illinois Lawmakers to Consider Expanded Funding for Elderly Health Care Programs and Voluntary Reporting of Elder Abuse

A statewide program to prevent elder abuse, expanded services for Alzheimer's disease victims and a continuation of one of the nation's largest in-home care programs for the elderly are included in Governor James R. Thompson's Fiscal Year (FY) 1988 budget request for the Department on Aging.

At $135.8 million, the Department budget is three percent larger than last year's spending plan and includes a $93.1 million request in state general revenue funds.

"Abuse of the elderly is a problem we don't like to hear about, but like child abuse, we know it's a real and tragic problem that needs to be squarely addressed," said the Governor.

"Three years ago, the Department on Aging began a demonstration program to gain more information about elder abuse. From that effort, we learned that a coordinated statewide response can serve not only the abused elderly, but also their abusers, who are most often family caregivers," he said.

FY 88 would be the first year of full implementation for the $1.2 million statewide program which would involve local groups, and call for a voluntary reporting system. The Department on Aging is currently drafting legislation to institute voluntary reporting of elder abuse by physicians and others. The program also includes assessment, casework, and follow-up. If enacted, the reporting would begin to phase in on October 1, 1987. It would be fully operative in all areas of Illinois by September 30, 1988.

For the victims of Alzheimer's disease and their families, Thompson said, "They will receive more attention, as more victims will be served through our adult day care programs and new pilot projects. In addition, senior companion demonstration programs will continue to employ low-income companions to assist the frail elderly, and several projects will continue to study the need for skilled home health care," he said.

The Governor's budget proposal includes $300,000 for the new Alzheimer's pilot project grants.

The Community Care Program, operating since 1980, also will be a priority in the new fiscal year. With a request of $82.2 million in state funding, the program represents one of the largest of its kind in the nation, providing chore/housekeeping, homemaker, case management and adult day care to frail individuals who would otherwise be institutionalized.

"General revenue funds directed to the program, which serves 25,000 clients, are partially reimbursed with federal Medicaid funds that became available to Illinois in 1983. A portion of the Medicaid dollars that previously were available only for nursing home care now can be directed toward in-home services if they are more appropriate for the client," said Department on Aging Director Janet S. Otwell.

The Department's budget proposal also includes more than $42.7 million in federal Older American Act funds, which are distributed to the state's 13 Area Agencies on Aging. The agencies contract with local providers for meal and transportation programs, case management, information and referral and a range of other services offered through senior centers and local aging offices.

More than 148,000 seniors participate in meal programs annually, and nearly 400,000 participate in other community-based services provided through federal Older Americans Act funding. Other programs provided by the Act include the Nursing Home Ombudsman Program, which works to improve the lives of older persons in nursing homes, and the Senior Community Service Employment Program, which provides part-time employment to low-income seniors throughout Illinois. ◀

Table 2
Agency Characteristics of the Situation*

Variable	Total	Percent
Report Source		
Alleged Victim	23	13.7
Spouse	2	1.2
Parent	0	0.0
Child	10	6.0
Other Relative	15	8.9
Caretaker	5	3.0
Roommate	0	0.0
Legal Guardian	0	0.0
Physician	1	0.6
Dentist	0	0.0
Social Worker	44	26.2
Nurse	20	11.9
Department on Aging Employee	0	0.0
Nursing Home/Other Institution	3	1.8
Paraprofessional	19	11.3
Anonymous	10	6.0
Other	17	10.1
Missing Data	7	4.2

**Reported 1986-1987. First seven months of year three of the Elder Abuse Demonstration Program. Published with permission of the Illinois Department on Aging.*

patients can take on their own behalf; to determine what actions you must take; to provide a supportive environment for the patient's decision-making; and to provide needed information and make appropriate referrals to available community resources. None of these guidelines alone indentifies elder abuse. However, any one of them should alert the physician to look more closely.

- Discrepancy between injury and history. Spilled coffee may cause burns on the front of the abdomen, arms or legs, but not usually on someone's back.
- Inappropriate injury or degree of injury versus history.
- Conflicting histories of injury.
- Vague explanation of injury, or denial in view of obvious injury.
- Bizarre or inappropriate explanation.
- Insistence that injury is severe when no injury exists.
- Long delay between the injury and the time treatment is sought.
- History of being "accident prone."
- History of many previous injuries, repeated emergency room or physician visits for injuries. History of seeking treatment from different medical providers.
- Untreated old injuries.
- Multiple injuries in various stages of healing, or repeated injuries of the same nature.
- Injuries on an area of the body normally covered by clothing.
- Injuries consistent with the shape of a weapon (*i.e.*, coat hangers, ropes, belts, irons, cigarettes, fingers).
- Bruising or laceration of lips from force feeding or being gagged.
- Whiplash-type injuries produced from severe shaking.
- Laceration, bruises or bleeding of the rectum or genitalia.
- Fractures in non-ambulatory patients.
- Alopecia or hemorrhaging beneath the scalp from hair pulling.
- Previous suicide attempts.
- History of prior physical abuse of patient or other family member.
- Malnutrition or dehydration; significant weight loss; bleeding gums or soreness of mouth and tongue.

Table 4
Characteristics of the Situation*

Variable	Total	Percent
Place of Abuse Incident		
Own Home, Alone	31	18.5
Own Home, with Others	83	49.4
Relative's Home	12	7.1
Friend's Home	1	0.6
Caretaker's Home	12	7.1
Unlicensed Facility	1	0.6
Other	20	11.9
Missing Data	14	8.3
Unknown	0	0.0
Type of Abuse Suspected		
Physical	47	28.0
Confinement	18	10.7
Sexual	0	0.0
Deprivation of Services	37	22.0
Other Abuse	72	42.9
Financial Exploitation	73	43.5
Passive Neglect	39	23.2
Self Neglect	29	17.3
Victim in Danger		
Yes	7	4.2
No	155	92.3
Missing	6	3.6
Victim Injured		
Yes	11	6.5
No	149	88.7
Missing	8	4.8
No Food/Shelter		
Yes	4	2.4
No	159	94.6
Missing	5	3.0

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Table 3
Demographic Data on Victims*

Variable	Rockford	Kankakee	Egyptian Area	N. Suburban Cook	Totals	Percent
Number of reports received	**23**	**24**	**56**	**65**	**168**	
Number of cases currently open	7	16	32	51	106	63.1

**Reported 1986-87. First seven months of year three of the Elder Abuse Demonstration Program. Published with permission of the Illinois Department on Aging.*

- Frequent, multiple or untreated decubiti.
- Overmedication or lack of proper medication.
- Poor personal hygiene. Odor of urine or fecal impactions.
- Broken or missing eyeglasses, false teeth and hearing aids.
- Anxiety or depression regarding family situation, such as not wanting to return home; nonverbal symptoms such as lack of facial activity; avoidance of eye contact with caretaker or leaning backwards.
- Psychiatric, drug or alcohol abuse history in patient or caretaker.
- Caretaker or family will not allow patient to be examined or interviewed privately.

If you suspect abuse, there are three important points to keep in mind. First, identification and treatment are complicated by fear, embarrassment or reluctance to admit the abuse.

Second, victims are "in crisis" when they arrive, have probably been traumatized over a long period of time by what experts call "the battering syndrome" and will exhibit symptoms of passivity, low self-esteem, and indecision which can often frustrate professionals trying to assist them.

Third, the battered adult must make his or her own decisions. It is not your responsibility to make decisions for the patient. You can provide them with information, emotional support and encouragement that will facilitate their own decision-making process. The following protocol should be helpful.

- Provide a quiet, private environment where confidentiality can be assured. Patient should be interviewed privately.
- Maintain an empathetic rapport with the patient. Give time for verbalization before beginning the physical assessment. Be reassuring and available for listening.

Table 5
Demographic Data on Abusers*

Variable	Total	Percent
Age of Abuser		
Age Range	11-98	
Mean Age	54	
Sex of Abuser		
Male	100	49.5
Female	93	46.0
Missing	9	4.5
Race of Abuser		
White	168	83.2
Black	12	5.9
Hispanic	1	0.5
Missing	19	9.4
Relationship to Victim		
Spouse	41	20.3
Former Spouse	2	1.0
Parent	0	0.0
Child	59	29.2
Other Relative	39	19.3
Caretaker	63	31.2
Roommate	56	27.7
Former Roommate	6	3.0
Legal Guardian	2	1.0
Other	31	15.3
Unknown	0	0.0
Missing	5	2.5

**Reported 1986-1987. First seven months of year three of the Elder Abuse Demonstration Program. Published with permission of the Illinois Department on Aging.*

- Clearly and accurately obtain and document:
  a. *Complete history of injury.* Note any of the above guidelines such as discrepancies between injury and history.
  b. *Physical Assessment.* Patient should undress and wear a gown so that any hidden areas will be exposed. Describe an injury in terms of type, location, severity and age.
  c. *Emotional Assessment.* Observe emotional status of patient and patient's interactions with family, caretakers and others.
- Ask about the abuse. Is there trouble at home? This may elicit a direct response. If not, the fact that you showed concern and think it is a possibility will make an impression and may help the elder to seek help later. In either case, offer to refer the elder for services now or at some future time.
- Discuss possible services. Encourage the patient to contact the Illinois Department on Aging at 1-800-252-8966 or their local Area Agency on Aging for assistance, and make any requested referrals.
- Follow-up. Hopefully, a follow-up call will be made to the elder to inquire about his/her condition.

The legal trend across the country has been to protect medical professionals from civil suits for good faith reports of abuse. Therefore, accounts from elders and tangible signs of abuse such as described previously should not be ignored. By reporting a case of suspected abuse, the physician triggers a mechanism for social service professionals to provide services. To report a case of suspected elder abuse, call 1-800-252-8966, or your local Area Agency on Aging. ◀

Sally Petrone, a protective services specialist with the State of Illinois Department on Aging in Springfield, manages the Elder Abuse Demonstration Program, and is currently developing the proposed statewide Elder Abuse Program. Ms. Petrone has been involved with issues regarding the aged for the past eleven years.

Carolyn Cochran is affiliated with the State of Illinois Department of Rehabilitative Services, Springfield, as chief of management analysis. At this writing, Ms. Cochran was the Elder Abuse Program manager for the State of Illinois Department on Aging in Springfield. Ms. Cochran, who completed a master's degree in social work from the University of Illinois under a National Institute of Mental Health fellowship, researched and designed the Elder Abuse Demonstration Program.

The Importance of Resident Involvement

By Rockford G. Yapp, III, M.D., Chairman, ISMS-RPS

Since the establishment of the American Medical Association Resident Physician Section ten years ago, residents from Illinois have played a major leadership role. The reason for this is the strong support from the Illinois State Medical Society. Because both residents and organized medicine benefit from increased involvement in the ISMS and the AMA, all members of ISMS should renew their efforts to increase resident participation in these organizations.

In 1976 the American Medical Association formed a Resident Physician Section (RPS) that allows physicians-in-training to participate in and influence the policies of the AMA. Over the years the AMA-RPS has grown to over 30,000 members, representing residents from all over the country in every subspecialty. During that time, residents from Illinois have played key roles in the formulation of RPS and AMA positions and policies. There have been five AMA-RPS Governing Council members from Illinois. In addition, the most important leadership position ever obtained by a resident in the AMA—the first voting resident member of the AMA Board of Trustees—was held by a resident from Illinois.

Resident members have played an equally important role in ISMS policymaking decisions. Much, if not most, of the initiation of an anti-smoking policy by ISMS and the AMA came about because of Illinois resident and medical student members. Illinois residents have also initiated resolutions on AIDS, teen pregnancy, graduate medical education and health care for the indigent. Residents have had major roles in subsequent policy development in organized medicine which have often influenced health policy in the country.

The success Illinois residents have had in national leadership roles can be directly linked to the support and guidance ISMS has given its resident members. In 1976 the ISMS House of Delegates approved formation of an ISMS Resident Physicians Section. This strong support is not without additional benefits to ISMS. AMA studies have shown that physicians who are members of organized medicine as residents are much more likely to continue their membership after completion of their training than those who were not members during residency.

Residents involved in leadership positions in organized medicine are much better informed about the many problems facing medicine today. They will have gained experience enabling them to be more effective and successful in facing the political, social and economic challenges of medical and patient care in the future. Other numerous benefits residents receive by joining organized medicine include: professional publications such as the *Journal of the American Medical Association,* the *Illinois Medical Journal,* the *AM News* and choice of a specialty journal; eligibility for professional liability insurance through the Illinois State Medical Inter-Insurance Exchange; help in coping with new forms of health care delivery systems; the option of serving as an advocate for the concerns of medicine in Springfield and Washington, D.C.; and information, financial and business services.

Because of these benefits to organized medicine and residents,

members of ISMS should renew their efforts in encouraging physicians-in-training to become involved in ISMS and the AMA. The best way to achieve increased involvement is by one-to-one contact. Attending physicians who have resident and student contact are in the best position to do this. Their experience and positions as role models to physicians-in-training can be much more successful than any membership brochure received in the mail. Practicing physicians who have little contact with residents can help by encouraging their county society to increase its efforts in resident recruitment and minimize obstacles that residents may face when joining the county medical society. Finally, resident members have an obligation to explain to their fellow residents the numerous benefits and advantages in becoming a member of ISMS and the AMA. In his 1985 address to the AMA-RPS Assembly, then AMA President Dr. Joseph Boyle said, "The residents of today are the future and the leaders of medicine tomorrow." Illinois, more than any other state, has provided the AMA with the strongest leadership in the country. In organized medicine, the importance of physicians-in-training cannot be overstated.

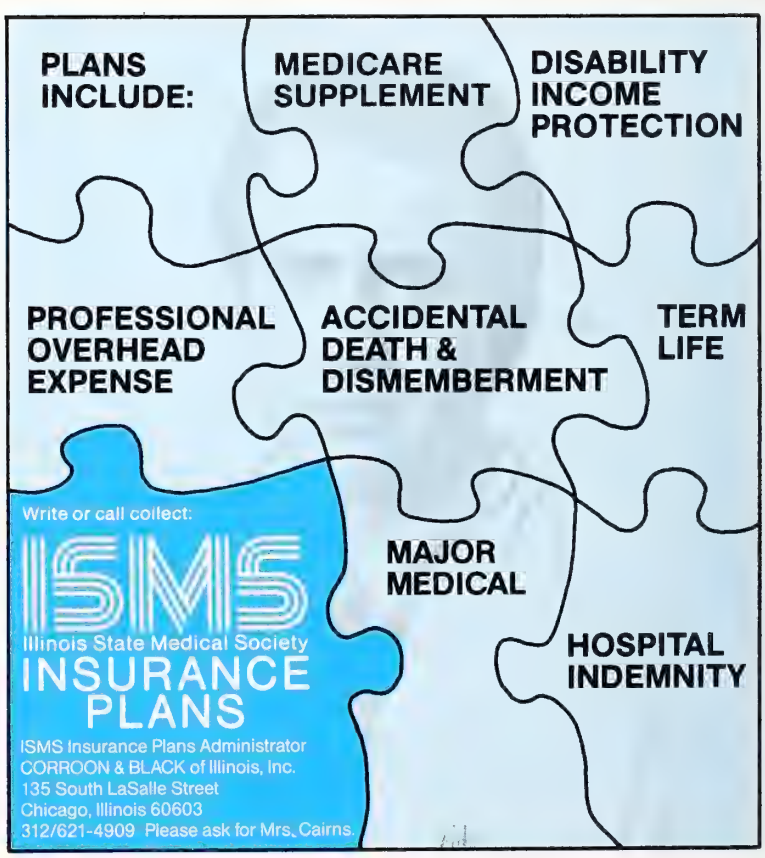
Renewed efforts to increase resident involvement and membership by all members of ISMS can only strengthen and better prepare physicians to help lead organized medicine and health policy in the future. ◀

SOLVE YOUR PROTECTION PUZZLE

The insurance puzzle... are there pieces missing from your picture?

As a member of ISMS, you can realize substantial benefits by participating in society-approved insurance plans. Designed and administered by professionals in cooperation with ISMS, this program could be the answer to your personal and professional needs. While your requirements receive individual attention, you also enjoy the economies of ISMS group purchasing power.

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In mild to moderate hypertension

Brief Summary

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CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDOSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVERDOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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"I Quit Clinics"

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

May 4	Grant Hospital	*Chicago*
May 4	West Suburban Hospital Medical Center	*Oak Park*
May 5	Lakeside VA Medical Center	*Chicago*
May 5	Northwestern Memorial Hospital	*Chicago*
May 5	Skokie Valley Hospital	*Skokie*
May 11	Lutheran General Hospital	*Park Ridge*
May 12	Carle Wellness Center	*Urbana*
May 12	St. Therese Medical Center	*Waukegan*
May 18	Condell Memorial Hospital	*Libertyville*
May 19	St. Elizabeth Hospital	*Chicago*
May 25	LaGrange Memorial Hospital	*LaGrange*
To Be Announced	Hinsdale Sanitarium and Hospital	*Hinsdale*
To Be Announced	Resurrection Hospital	*Chicago*
To Be Announced	West Town Public Health Clinic	*Chicago*

DOCTOR'S NEWS

1986 MEMBERSHIP AWARD GIVEN TO ISMS

ISMS was named a recipient of the 1986 AMA Membership Award. The American Medical Association presents the award to medical societies which have increased their membership numbers from the previous year. This is the second consecutive year ISMS has received this honor. Jere E. Freidheim, M.D., ISMS president, accepted the award during the February National Leadership Conference held in Chicago.



AMA President-Elect William S. Hotchkiss, M.D., presents ISMS President Jere E. Freidheim, M.D., with the 1986 Membership Award for another consecutive year of exceeding prior year AMA membership.

DR. DAVIS TO HEAD CDC OFFICE

Ronald M. Davis, M.D., has been named director of the Centers for Disease Control's (CDC) Office on Smoking and Health in Rockville, Maryland.

The major activity of the Office on Smoking and Health is the preparation of the surgeon general's annual report on the health hazards of smoking. Dr. Davis, a medical epidemiologist in the CDC's health education division, has been very involved in smoking prevention and education. He is a graduate of the University of Chicago's Pritzker School of Medicine and has a master's degree in public policy from the University of Chicago.

Dr. Davis was chairman of the Governing Council of the American Medical Association Medical Student Section from 1982-1983, and was elected the first resident member of the AMA's Board of Trustees in 1984. He was scheduled to begin his new position in February.

PHYSICIANS IN THE NEWS

John S. Long, M.D., Chicago, was honored recently with the Chicago Medical Society's 10th Public Service Award. Dr. Long, a senior attending surgeon at Rush-Presbyterian-St. Luke's Medical Center and associate professor of obstetrics and gynecology at Rush Medical College, is a founder and member of the board of the American Refugee Foundation, an organization that recruits volunteer health care professionals to care for the sick of third world countries. . . . **George M. Gallant, M.D.,** Woodstock, was named chairman of the Emergency Medical Services Commission of Metropolitan Chicago. Dr. Gallant, certified in emergency medicine, is director of emergency medicine at Northern Illinois Medical Center. . . . **Frank Gonzalez-Crussi, M.D.,** Wilmette, has been appointed head of the department of pathology at The Children's Memorial Hospital, Chicago. Formerly head of the division of anatomic pathology, Dr. Crussi has been affiliated with Children's since 1978. . . . **Robert J. Becker, M.D.,** was installed as president of the American College of Allergists at its 43rd Annual Congress in January. A clinical allergist for 26 years, he serves on the advisory council of the National Institute of Environmental Health Sciences, and is a past president of both the Professional Standards Review Organization and the Illinois Society of Internal Medicine.

Two attending physicians at the Rehabilitation Institute of Chicago were recently named to administrative positions. Appointed the Center's director was **E. Richard Blonsky, M.D.,** Glencoe, an associate director of the Institute's Center for Pain Studies and an associate professor in the departments of clinical neurology and rehabilitation medicine at Northwestern University Medical School. Named associate director of RIC's Spinal Cord Injury Rehabilitation Program was **Elliot J. Roth, M.D.,** Chicago, an assistant professor in rehabilitation medicine at Northwestern University Medical School. . . . **Donald F. Pochyly, M.D., F.A.C.P.,** River Forest, was appointed vice-president for medical affairs at Saint Mary of Nazareth Hospital Center, Chicago. Dr. Pochyly, a professor of clinical medicine at the Loyola University Stritch School of Medicine, Maywood, also coordinates the medical school's geriatric training programs. He is chairman of the Illinois State Medical Society Continuing Medical Education Accreditation Committee. ◀

PHYSICIANS



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Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

May

Health Care

Symposium: The Transformation of the American Health Care System **For:** Interested physicians. Symposium, May 1-2, Mead Inn, Wisconsin Rapids, WI. **Sponsors:** The State Medical Society of Wisconsin and the Riverview Hospital Association, 410 Dewey St., Wisconsin Rapids, WI 54494. **Fee:** $145. **Reg. Limit:** None. **Credit:** Applied for. **Contact:** Riverview Hospital Association. **Phone:** (715) 423-6060, Ext. 410.

Neuroradiology

1987 Neuroradiology Review Course
For: General radiologists, neuroradiologists, neurosurgeons, neurologists, and residents. Course, May 2-3, Oakbrook Marriott Hotel, Oak Brook, IL. **Sponsor:** Loyola University Medical Center, 2160 South First Avenue, Maywood, IL 60153. **Fee:** $170 for physicians and $100 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3237.

Family Practice/Cardiology/Internal Medicine/Pulmonary

48th Annual Theodore Lang May Day Clinic
For: Physicians, residents, students, and nurses. Seminar, May 1-2, Clock Tower Inn, Rockford, IL. **Sponsors:** St. Anthony Medical Center, 5666 East State St., Rockford, IL 61108 and University of Illinois College of Medicine at Rockford and the Rockford Medical Education Foundation Family Practice Residency Program. **Fee:** $125. **Reg. Limit:** 500. **Reg. Deadline:** April 15 (late registration: May 1). **Credit:** Category 1: 9 hours. **Contact:** Betty Noegel. **Phone:** (815) 226-2000, Ext. 5190.

Internal Medicine

Pulmonary Function Evaluation
For: Physicians. Lecture, May 5, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Midwestern Study Conference
For: Primary care physicians. Lectures and workshops, May 20-22, Chicago. **Sponsor:** Chicago College of Osteopathic Medicine, 5200 S. Ellis Avenue, Chicago, IL 60615. **Fee:** $150. **Reg. Limit:** None. **Credit:** Category 1: 24 hours. **Contact:** Hope Wheeler. **Phone:** (312) 947-4983.

Advances in Internal Medicine, 1987
For: Internists. Lecture, May 18-21, Atlanta, GA. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $450. **Reg. Limit:** None. **Credit:** Category 1: 34 hours. **Contact:** Robert J. Baker, M.D., **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Hypertension and Quality of Life
For: Physicians. Lecture, May 26, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115 and Pfizer Laboratories. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Pathology

Current Problems in Cervical Neoplasia
For: Pathologists. Lecture, May 11, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Radiology

Mammography
For: Physicians. Lecture, May 12, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Infectious Diseases

Fever—Undetermined Origin
For: Physicians. Lecture, May 19, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

General Medicine

Diabetes Update, 1987—A Clinical Conference
For: Physicians, nurses, and dieticians. Symposium, May 30, Holiday Inn Conference Resort, Decatur, IL. **Sponsor:** American Diabetes Association, Downstate Illinois Affiliate, Inc., 965 N. Water, Decatur, IL 62523. **Fee:** $40. **Reg. Limit:** 200. **Reg. Deadline:** May 26. **Credit:** Category 1: 5 hours. **Contact:** Donna Scott. **Phone:** (217) 422-8228.

Malpractice

Medical Malpractice and the Doctor/Patient Relationship
For: Physicians. Conference, May 21, Milwaukee, WI. **Sponsors:** Center for the Study of Bioethics, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226 and St. Luke's Hospital, Milwaukee. **Fee:** $100. **Reg. Limit:** None. **Credit:** Category 1: 4.5 hours; CEU: 4.5 hours. **Contact:** Anne Marie Talsky. **Phone:** (414) 257-8692.

Venous Disease

Venous Ultrasonography and Venous Disease Symposium
For: Radiologists, vascular surgeons and technologists. Symposium, May 1-2, Chicago O'Hare Marriott, Chicago. **Sponsor:** The Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** $275 for physicians and $225 for technicians. **Reg. Limit:** 300. **Reg. Deadline:** May 1. **Credit:** Category 1: 15 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Nutrition

Contemporary Clinical Nutrition
For: Nutritionists, G.I. and oncology specialists. Lecture, May 8-10, Chicago O'Hare Marriott, Chicago. **Sponsor:** The Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** $295 for physicians; $245 all others. **Reg. Limit:** 500. **Reg. Deadline:** May 8. **Credit:** Category 1: 20 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Anthesthesiology

Specialty Review in Anesthesiology
For: Anesthesiologists. Lecture, May 10-15, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $790. **Reg. Limit:** None. **Credit:** Category 1: 54 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Sports Medicine

Tenth Annual Sports Medicine Program
For: Physicians and allied health professionals. Symposium, May 14-16, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, School of Medicine, Section of Sports Medicine and the University of Wisconsin Hospital, Sports Medicine and Fitness Center. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 20 hours; AAFP: credit pending; AOA: Category 2-D: 20 hours; Other: American College of Sports Medicine: endorsement pending. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Ophthalmology

Annual Residents-Alumni Day Meeting
For: Alumni and all area ophthalmologists. Lecture and papers presentation, May 15, Eye & Ear Infirmary, University of Illinois, Chicago. **Sponsor:** University of Illinois at Chicago, Dept. of Ophthalmology, 1855 W. Taylor Street, Chicago, IL 60612. **Reg. Limit:** None. **Credit:** Category 1: 7 hours. **Contact:** Joan Sunseri. **Phone:** (312) 996-4554.

Surgery

Microneurosurgery: A Surgical Techniques Workshop
For: Neurosurgeons. Workshop, May 16-21, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $3,500. **Reg. Limit:** 60.**Credit:** Category 1: 50 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Warren H. Cole Symposium XIV
For: Surgeons. Lecture, May 27-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $75. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Cardiology
The Initial 6 Hours of Acute Myocardial Infarction
For: Physicians. Symposium, May 21, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $35 **Reg. Limit:** 300. **Credit:** Category 1: 7.5 hours; AAFP Prescribed: 7.5 hours; and ADA: 7.5 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Pediatrics
Specialty Review in Pediatric Hematology/Oncology
For: Pediatric hematologists-oncologists. Lecture, May 27-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $435. **Reg. Limit:** 90. **Credit:** Category 1: 26 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Family Medicine
Specialty Review in Family Medicine
For: General and family practitioners. Lecture, May 31-June 6, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $740. **Reg. Limit:** 90. **Credit:** Category 1: 72 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

June

Obstetrics/Gynecology
Obstetrics and Gynecology Review Course
For: Obstetricians and gynecologists. Course, June 8-13, Chicago. **Sponsors:** Medical Schools of Illinois, c/o The University of Chicago, School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $550 **Reg. Limit:** None **Credit:** Category 1: 39 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 902-1056.

Cardiology/Psychiatry/Family Medicine
Cardiovascular Pharmacology Symposium: Pharmacologic and Clinical Interrelationships Between the Heart and the Brain.
For: Physicians and other health professionals. Symposium, June 10-12, Milwaukee, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, Cardiovascular Disease Center and Dept. of Psychiatry, Milwaukee Campus, Mt. Sinai Medical Center, and Continuing Education and Research Foundation, Inc., Milwaukee, WI. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 17 hours; AAFP Prescribed: Credit pending; AOA Category 2-D and University of Wisconsin CEUs: 17 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Otolaryngology
Myocutaneous Flap Reconstruction of the Head and Neck
For: Otolaryngologists. Workshop, June 12-13, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $600. **Reg. Limit:** 60. **Credit:** Category 1: 16 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Endoscopic Sinus Surgery
For: Otolaryngologists. Workshop, June 20-21, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $700. **Reg. Limit:** 60. **Credit:** Category 1: 12 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Family Practice/Internal Medicine/Oncology
Clinical Home Care in the 1980s: Economics, Implementation, and Ethical Issues
For: Physicians and other health professionals. Conference, June 25-26, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, Dept. of Medicine, School of Medicine, Regional Services/Home Care, Nutritional Sciences, Pharmacy Dept.; and Visiting Home Services. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 13 hours; AAFP Prescribed: Credit pending; AOA Category 2-D: 12½ hours; Univ. of Wisconsin CEU's: 13 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

July

Stress Management and Relaxation Skills
Teaching Stress Management and Relaxation Skills
For: Physicians and other health professionals. Workshop, July 13-17, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, LaCrosse Exercise and Health Program, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP: 35 hours; and 3.5 CEUs from UW-LaCrosse. **Contact:** Philip K. Wilson, Ed.D., University of Wisconsin-LaCrosse. **Phone:** (608) 785-8686.

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How to Hire a Medical Assistant

By Lesa Hildebrand, CMA-C/River Grove

Have you ever needed to hire a medical assistant but cringed at the thought of interviewing countless individuals responding to a newspaper ad? Many people are not aware of the medical assisting profession. As a result, many other allied health personnel consider themselves medical assistants since they assist a physician in some capacity. However, most of these professionals are not as diversified as the medical assistant.

Illinois offers four CAHEA-accredited medical assisting programs, all of which provide a variety of administrative and clinical skills. Administrative skills may include typing, insurance coding, computer use, machine transcription and minor training in bookkeeping and accounting. Clinical skills may include obtaining vital signs and ECGs, phlebotomy and audiometry, and laboratory functions. Programs range in length from one year to two years. Graduates of the one year programs receive a certificate or diploma, while graduates of two year programs receive an associate degree in applied science.

All of the accredited medical assisting programs provide an externship for the students. This externship is generally offered near completion of the formal program and enables the students to utilize the skills they have learned. Students receive credit for this externship and function as part of the office staff.

Most programs conclude at the end of May. Graduates are strongly urged to take the national certifying examination for medical assistants, developed in consultation with the National Board of Medical Examiners, offered on the first Friday in June. The graduate is considered a certified medical assistant upon successful completion of this examination.

How does a physician-employer secure one of these highly-trained individuals? Your best option would be to contact a coordinator from an accredited medical assisting program near you. This person is usually in touch with graduates, or can forward information as appropriate.

Four Illinois program coordinators can be reached at the following addresses. Contact Lesa Hildebrand at Triton College, 2000 Fifth Avenue, River Grove 60171; (312) 456-0300, extension 293 or 438. At Harper College please ask for Vera Davis, R.N., CMA, Algonquin & Roselle Roads, Palatine 60067; (312) 397-3000. The Belleville Area College coordinator is Rose Hall, R.N., CMA-AC, 2500 Carlyle Avenue, Belleville 62221; (618) 235-2700, extension 332. The Robert Morris coordinator is Judith Marshall, M.T., CMA-C, Carthage 62321; (217) 357-2121.

A list of coordinators of accredited medical assisting programs in bordering states may be obtained from the AAMA at (312) 899-1500. Another way to secure qualified employees is to contact the president of the Illinois Society of Medical Assistants, Cheryl Hutchison, at (618) 451-4800. She can provide the name of the local chapter president, who can forward the information at their monthly meeting. These meetings are generally attended by experienced medical assistants who may be in need of employment, or who can forward this information to qualified individuals seeking employment.

Information regarding the Illinois Society of Medical Assistants and/or medical assisting can be obtained from Cheryl Hutchison, CMA, president, Illinois Society of Medical Assistants, 53 Lockhaven, Granite City 62040; Robin Bluestein, CMA-C, co-chairman, public relations committee, 2247 West Estes, Chicago 60645; Catherine M. Hill, CMA, 900 South Plum Grove Road, Palatine 60067. ◂



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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—to join an established four member group of general internists in Bloomington-Normal, Illinois. Complete office facilities. Midwestern University community with strong economic base. Contact: Judy Buchanan, Administrative Director, The Health Center, 702 North East Street, Bloomington 61701, (309) 827-5051. (6)

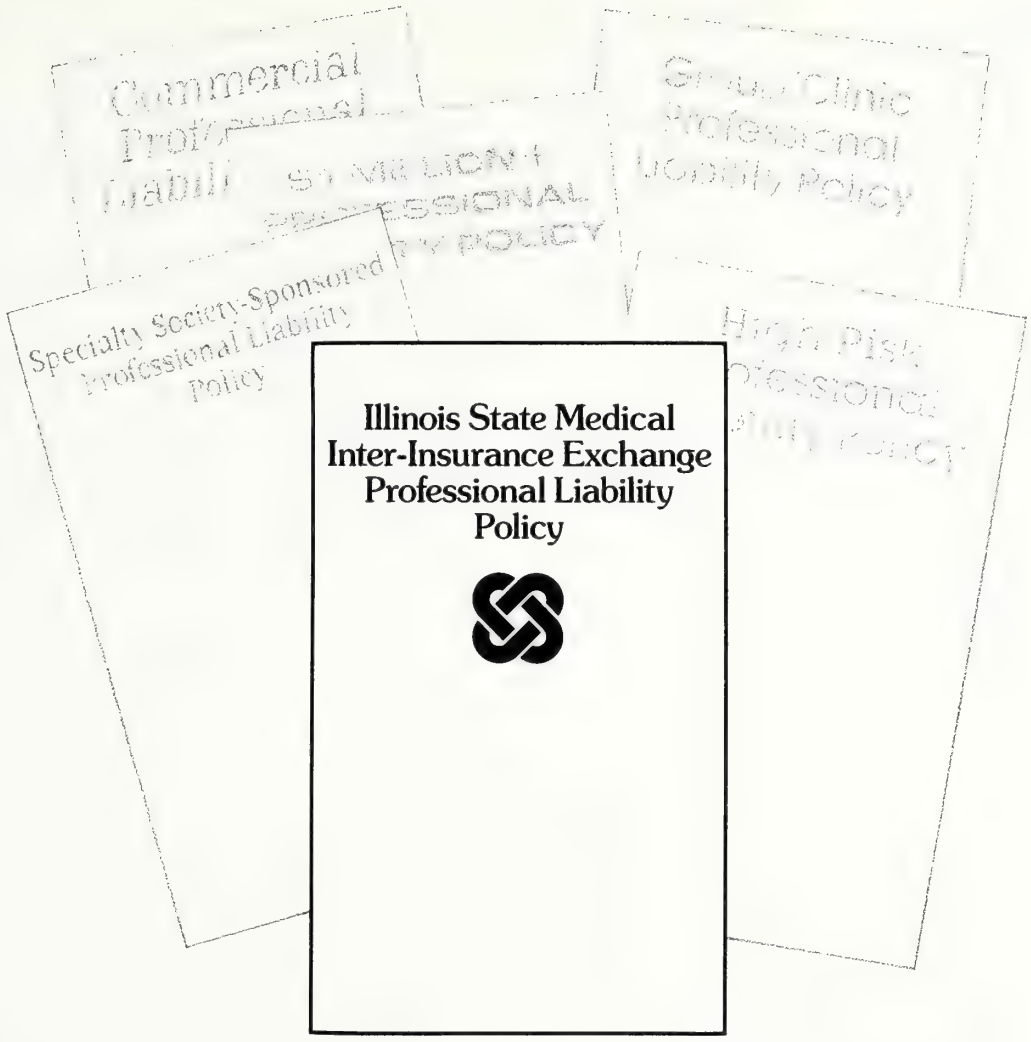
GIBSON CITY:
Opportunities for Family Practice and Internal Medicine either in partnership with a family practitioner or in solo practice. Fully equipped office facility and income support arrangements available. Stable farm community serving 20,000 population within a 20 mile radius. 30 miles north of Champaign-Urbana. Three hour drive south of Chicago. Contact: Terry Thompson, Administrator, Gibson Community Hospital, 1120 North Melvin Street, Gibson City 60936, (217) 784-4251. (4)

GRAYVILLE:
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LA HARPE:
Rural western Illinois community of 1500 (service area of 5,000) is seeking a Family Physician. Good schools, close to Mississippi River, within 25 miles of university. Small community hospital affiliated with regional medical center. Guarantee plus moving expenses. Contact: Byron Mueller, M.D., 112 Main St., La Harpe 61450, (217) 659-7613, or Richard Miller, Administrator, La Harpe Hospital, B St. & Archer Ave., La Harpe 61450, (217) 659-3011. (6)

PEKIN:
Opened new 20-office multi-specialty physician's medical center attached to Pekin Memorial Hospital, a 202-bed progressive community hospital. Competitive income guarantee and relocation allowance available. Contact: Ruth Campbell, Court and 14th Streets, Pekin 61554. (1)

PITTSFIELD:
Illini Community Hospital. Practice opportunities for FP, OB/GYN, Internist and Pediatrician; solo or partnership. Office space and financial assistance available. Service area 25,000. Excellent outdoor recreation. Close to St. Louis and Springfield. Good school systems, including colleges and universities. Contact: Kathleen Wegener, 640 W. Washington, Pittsfield 62363, (217) 285-2113. (2)



A disappearing act?

The number and size of damage claims against physicians continues to rise. And it's drying up most sources of malpractice insurance for Illinois doctors.

But there's one company that will still be here even if all the others are gone. The Illinois State Medical Inter-Insurance Exchange.

The Exchange is a company owned and operated by its policyholders. As such, we put our policyholders ahead of profit.

Unfortunately, the Exchange is not immune from the ravages of the current legal situation. The shrinking availability of backup insurance protection is forcing us to offer only claims-made policies after July 1.

But even with claims-made, we intend to make sure that Exchange policyholders will continue to have the best professional liability protection available. The same aggressive defense of frivolous suits. And programs to help you avoid the incidents that can lead to malpractice suits.

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Twenty North Michigan Avenue
Suite 700
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(312) 782-2749 800-782-ISMS (Toll-Free)

Springfield Memo

(Continued from page 206)

system. A number of professional and voluntary health associations have been asked to assist in the proposal's development. If granted, the funds will provide for a wide variety of data gathering activities, assist in training of staff and develop computer capabilities of the state.

(Source: January 8, 1987 meeting of IDPH Cancer Proposal Committee)

AIDS Education Program

IDPH has awarded ISMS a grant to develop seminars and educational materials for physicians on dealing with AIDS patients. The topics to be covered include epidemiology, transmission, patient counseling, diagnosis and treatment modalities.

Persons interested in hosting or attending programs or receiving information on these topics should contact the ISMS Division of Educational and Medical Services.

Designation of Regional Poison Resource Centers

IDPH is in the process of requesting hospitals to submit applications for designation as the Regional Poison Resource Center for the 32-county northern and central Illinois service area. There are only three designated regional poison resource centers in the state which provide free information and treatment consultation to the public, hospitals, physician offices and other health agencies.

The hospital designated will have to meet certain criteria and provide acute poison information, product identification, poison education and necessary referral services 24 hours a day, seven days a week, via an 800 toll-free number.

Persons interested in submitting an application should contact Leslee Stein, R.N., M.S., Chief, Division of EMS/HS, IDPH, 535 W. Jefferson, Springfield, IL 62761, or call 217-785-2080.

(Source: Correspondence from IDPH Director B. Turnock, 2/16/87)

From the Department of Registration and Education (DRE)

Medical Discipline Orders

- *Emery Berczeller (lic.# 036-036529)*
  Effective February 5, 1987, Dr. Berczeller's medical license was indefinitely suspended.
- *Howard Jay Berman (lic.# 036-054843)*
  Effective November 28, 1986, Dr. Berman's medical license was indefinitely suspended.
- *William Louis Daugherty (lic.# 003-036-032985)*
  Effective November 25, 1986, Dr. Daugherty's controlled substance license was restored, but placed on probationary status for one year.
- *Charles Goodell, III (lic.# 036-054510 & 003-036-054510)*
  Effective December 23, 1986, Dr. Goodell's medical and controlled substance licenses were restored.
- *Gerald T. Hanley (lic.# 036-041765 & 003-036-041765-1)*
  Effective December 9, 1986, Dr. Hanley agreed to limit his practice to radiology. He further agreed to discontinue writing controlled substances.
- *Gregory K. Huss (lic.# 003-036-00520)*
  Effective January 9, 1987, Dr. Huss' medical and controlled substance licenses were indefinitely suspended and subject to his meeting certain conditions.
- *Scott H. Isaacman (lic.# 036-064839)*
  Effective December 16, 1986, Dr. Isaacman's medical license was suspended for one year and, following that time, will be placed on probation for two years.
- *Nasreen Khan (lic. #036-056673 & 003-036-056673-1)*
  Effective December 9, 1986, Dr. Kahn's controlled substance license was placed on probation for one year.
- *Terry K. Kushner (lic. #036-061827 & 003-036-061827-1)*
  Effective January 27, 1987, Dr. Kushner's medical license was suspended retroactively from November 5, 1986 to March 1, 1987. Following that time, his license will be placed on indefinite probation. In addition, his controlled substance license was indefinitely suspended.
- *Joel M. Levin (lic. # 036-035220)*
  Effective February 10, 1987, Dr. Levin's medical license was suspended for nine months.
- *Mark Mench (lic. # 036-061486)*
  Effective December 16, 1986, Dr. Mench's medical license was moved from suspended to probationary status, subject to certain conditions.
- *James G. Middleton (lic. # 036-038955)*
  Effective March 5, 1987, Dr. Middleton's petition for restoration was denied and his license remains revoked.
- *Lowell F. Millburn, Jr. (lic. # 036-039817 & 003-036-039817)*
  Effective November 2, 1986, Dr. Millburn's medical and controlled substance licenses were indefinitely suspended, but for not less than two years.
- *Tadeusz Niedzielski (lic.# 036-033816 & 003-036-033816)*
  Effective January 22, 1987, Dr. Niedzielski's medical and controlled substance licenses were indefinitely suspended.
- *Marvin F. Powers (lic. # 036-042278 & 003-036-042278)*
  Effective November 25, 1986, Dr. Powers' medical

license was placed on probation for not less than one year and his controlled substance license was suspended for not less than one year.

- *Ciney R. Rich (lic. # 036-038840)*
  Effective November 28, 1986, Dr. Rich's medical license was indefinitely suspended.
- *Harry J. Schneider (lic. # 036-055554 & 003-036-055554-1)*
  Effective November 25, 1986, Dr. Schneider's medical and controlled substance licenses were suspended, but the suspensions were stayed and the licenses were placed on indefinite probation.
- *Louisa Bea Schneider (lic. # 036-055956 & 003-036-055956-1)*
  Effective November 25, 1986, Dr. Schneider's medical and controlled substance licenses were suspended, but the suspensions were stayed and the licenses were placed on indefinite probation.
- *Chi Feng Su (lic. # 036-049693 & 003-036-049693)*
  Effective December 3, 1986, Dr. Su's medical and controlled substance licenses were suspended pending a hearing.
- *Horton Earl Tarpley (lic. # 036-032818)*
  Effective November 28, 1986, Dr. Tarpley's medical license was indefinitely suspended.
- *Phillip Scott Zimmerman (lic. # 003-036-059066-1)*
  Effective November 25, 1986, Dr. Zimmerman's controlled substance license was restored, but placed on a one-year probation.

(Source: Orders received from DRE)

New Licensing Process

DRE has revised its forms and procedures to handle temporary and permanent license applications. New scannable forms and computer software will permit the state to process applications much more rapidly, and easily track an application during each stage of review. Seminars were held in January for hospital personnel to acquaint them with the new forms and system.
(Source: DRE correspondence)

Persons interested in additional information on any of the above items may contact the ISMS Division of Educational and Medical Services. ◀

ISMS Physician Help Line

Are you troubled by chemical dependency, alcoholism, physical or mental problems, or concerned about someone who has an impairment? Are you having problems dealing with your involvement in a malpractice suit?

If so, contact the PHYSICIAN HELP LINE, 312/580-2499, a confidential, advocacy service offered by the ISMS Impaired Physician Program and the Physician Support Group to link troubled physicians and their families with resources to help them.

The Physician Help Line is open 24 hours, 7 days a week. Calls will be answered as soon as possible, and information is shared only with the physicians helping the person who calls.

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EKG

(continued from page 211)

Answers: 1. C, D 2. A, D

This twelve lead ECG shows a normal sinus rhythm with normal PR and QRS intervals and a frontal plane QRS axis of approximately +50°. There is prominent ST segment elevation in leads II, AVF, V_2 to V_6. The ST segment is concave, upward in contour. The upward concavity of the ST segment is elevated up to three millimeters (mm) above the baseline in lead V_3. The ST segment vector points leftward, inferiorly and anteriorly. Although compatible with pericarditis, the absence of a pericardial friction rub makes this diagnosis less likely. A current of injury or infarction usually has downward concavity. In addition, the Q waves are not deep enough or wide enough to be diagnostic of infarction. This ST segment elevation is most likely early repolarization or a normal variant. ST segment elevation of early repolarization can range up to four millimeters, although usually it is two millimeters or less in the precordial leads. According to Lamb, fewer than nine percent of normal young males will have no ST segment elevation at all in any precordial lead.[1] The RsR′ configuration in lead V_1 has an R/S ratio of one, suggesting right ventricular hypertrophy of the volume overload type. An echocardiogram showed an enlarged right ventricular cavity and no pericardial effusion.

The ECG, echocardiogram and physical examination suggest this patient has an atrial septal defect. Cardiac catheterization showed an oxygen step-up at the right atrial level from 70%-83% oxygen saturation. The analysis demonstrated a 2.4-to-1, left-to-right shunt at the atrial level. Right heart pressures were all normal. The patient underwent a successful repair of the atrial septal defect.

No good explanation was found for the atypical chest pain. While chest pain can occur with atrial septal defect, it is uncommon, and often associated with pulmonary hypertension. Dyspnea-on-exertion is the most common adult symptom.[2] The patient did well postoperatively and in recovery, and had no further chest pain. ◀

References

1. Lamb, Lawrence E: Electrocardiography and Vectorcardiography. Philadelphia, W. B. Saunders Company, 1965.
2. Craig, R. J., Selzer, A.: "Natural History and Prognosis of Atrial Septal Defect," *Circulation* 37:805-815, 1968.

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FAMILY PRACTITIONER—BC/BE wanted to join busy practice in highly desirable Chicago suburb (Geneva). Send C.V. to: Dr. John Kelly, 13 S. Second St, Geneva, IL 60134. (312) 232-0319.

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sive hospital equipped with CT scanner. Service population of 60,000/80,000. University community. Reply: Administrator, 2501 Main St., Stevens Point, WI 54481; or call collect (715) 344-4120.

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WOMEN'S ORIENTED MEDICAL Clinic looking for family practitioner or internist—room to grow. 45 miles west of Chicago. Reply to Women's Health Center, 1240 North Highland Avenue, Suite 17, Aurora, IL 60506.

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TWENTY-NINE PHYSICIAN multispecialty clinic located in desirable east central Wisconsin location is seeking board certified or board qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested, contact D. F. Sweet, M.D., Fond du Lac Clinic, S.C., 80 Sheboygan Street, Fond du Lac, Wisconsin 54935.

OBSTETRICIAN/GYNECOLOGIST—Young, ten-physician, multispecialty group near St. Louis, seeks second OB/GYN. Virtually all deliveries are at a 220-bed hospital with a 25-bassinet Level II nursery. The group moved into a new 9,000 square foot, well equipped clinic building in 1985. For detailed information, send your C.V. or call: Jim Huber, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; (414) 785-6500 (collect).

ORTHOPEDIC SURGEON, emergency medicine, family practice, OB/GYN, general internist & ENT—needed for two-hospital, historic river town of 20,000. Drawing area of approximately 60,000 with new 19,000 acre recreational lake. Unlimited potential. Contact: Carol Neil, Physician Recruitment, 623 Broadway, Hannibal, MO 63401; or call (314) 221-3107.

LOCUM TENENS, OPHTHALMOLOGY: Illinois licensure and insurance required. Reply to Box #2050, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Deborah Bergun, Staffing Specialist. National Emergency Services, Inc. 255 Executive Drive, Suite 104, Plainview, NY 11803; or call (800) 645-4848, or (516) 349-0100.

FACULTY—AMBULATORY PEDIATRICS— the department of pediatrics, University of Illinois College of Medicine at Peoria, has a full-time faculty position available March 1, 1987, or after. Teaching, service and research responsibilities. Board certified/eligible in pediatrics. Training in adolescent medicine desirable. Preference given to active clinical practice brought into University program. Rank and salary commensurate with qualifications and responsibility. The University of Illinois is an affirmative action-equal opportunity employer. Send curriculum vitae and three reference letters to: William H. Albers, M.D., Professor and Chair, Department of Pediatrics, University of Illinois College of Medicine at Peoria, Box 1649, Peoria, IL 61656. Phone: (309) 655-2570.

EMERGENCY MEDICINE—Level I Trauma Center. Major university teaching hospital is conducting a search for emergency department physicians. Excellent remuneration and challenging medical environment. Interested applicants should send resume to: Barry R. Trautman, HealthLine Physicians Services, 8401 Hanley Industrial Court, St. Louis, MO 63144.

CARDIOLOGIST, B/E, B/C: Looking for associate in the established practice of cardiology. Excellent opportunity; modern progressive hospital in an ideal southern family community. Reply to Box #2053, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FAMILY PHYSICIAN wanted for salaried position in enchanting rural New Mexico. Small hospital, E.R., obstetrics a must. Community Health Center in Cuba, New Mexico, tricultural area, national forest setting. Skiing and mountain sports nearby. Board eligible/certified desired. Excellent benefits, malpractice paid. Write or call today: Physician for Cuba, c/o New Mexico Health Resources, P.O. Box 27650, Albuquerque, NM 87125; (505) 242-0633.

PHYSICIAN OPPORTUNITIES: Current opening full or part-time for BC/BE physician in family practice/internal medicine—solo, group or clinic based positions including Women's Health Center and/or Convenient Care Center. Salary excellent; malpractice and relocation expenses included. Located in 350,000 population area with family oriented environment. Please send curriculum vitae to: Constance Stahler, Franciscan Medical Center, 2701 17th Street, Rock Island, IL 61201; or call collect (309) 793-2200.

FAMILY PRACTICE PHYSICIAN—Board eligible or certified. Training/interest in obstetrics preferred. Full-time position available August '87 with established community health center in St. Louis. Contact V. Appoo Koenig (314) 241-2200, or mail resume to Grace Hill Health Center, 2500 Hadley, St. Louis, MO 63106.

ANESTHESIOLOGIST WANTED for permanent, part-time position at 185-bed community/area hospital in northwest Illinois community of 30,000. Currently have three full-time and one part-time anesthesiologists, and desire to utilize additional operating room daily. Plan is for three days per week, and vacation coverage. Call status negotiable. If interested, send resume to M. A. Belinson, M.D., Director of Anesthesiology Department, Freeport Memorial Hospital, 1045 West Stephenson Street, Freeport, IL 61032.

INVASIVE CARDIOLOGIST urgently needed in midwestern university city. Draw from 150,000+ population base. Open lab with fully trained staff in facility with open heart surgery program. Enjoy competitive first-year guarantee plus productivity and benefits. Only highly qualified and aggressive individuals need apply. Send C. V. to James Russell, Inc., P.O. Box 427, Bloomington, IL 61702; or call (309) 663-9467.

CORRECTIONAL HEALTH SERVICES is seeking board-eligible or board-certified family practitioners and internists for full and part-time positions in Illinois Department of Corrections facilities. Occupational health: Also needed are experienced physicians in occupational health with emphasis on program development for established clinics with industrial base in Chicago area. For more information send C.V. to Stanley Harper, M.D., Correctional Health Services, 467 W. Deming, Suite 704, Chicago, IL 60614; (312) 883-8705.

EMERGENCY MEDICINE SPECIALIST— Associate trauma center seeks additional emergency medicine specialist to join its progressive team which serves a 202-bed hospital. Center has average of 1,350 visits per month. Highly competitive salary and full-range of fringe benefits. Reply with C.V. to Nels Calvert, M.D., Pekin Memorial Hospital, Court & 14th Streets, Pekin, IL 61554; or call (309) 353-0430.

FAMILY PHYSICIANS needed to fill career opportunities in Illinois. Practice sites located throughout Illinois and include all types of opportunities. For information send your C.V. to the Illinois Academy of Family Physicians, 1200 Harger Road, Suite 722, Oak Brook, IL 60521.

EMERGENCY DEPARTMENTS STAFFED and managed by Fischer Mangold in several Illinois hospitals, have a few select openings available for dedicated, caring professionals board certified or prepared in emergency medicine. As an independent subcontractor you can enjoy the practice of medicine while the business of medicine is handled by skilled professional managers. Established in 1965, Fischer Mangold provides excellent compensation, stability, career ladder opportunities, group liability insurance, CME, and positions with well trained and experienced peers. Your inquiry is invited. Fischer Mangold, Brian Legg, PO Box 788, Pleasanton, CA 94566; (800) 227-2092.

PUBLIC HEALTH DIRECTOR sought by Will County Board of Health to replace retiring director. Responsible to 8-member, appointed board for department with 163 employees and $4.9 million budget. Salary $45,000-$50,000 depending on experience and qualifications. Minimum requirement alternatives: M.D. degree with appropriate experience; master's degree in public health or public administration with six years related experience; or bachelor's degree in related field and eight years appropriate experience. Send resume with credential evidence, professional references and current salary in confidence, not later than May 1, 1987 to John R. Gallagher, Jr., Will County Personnel Director, 302 N. Chicago St., Joliet, IL 60432.

F. M. G. INTERNIST: Busy, rural Illinois internist needs associate for general medicine practice. Guaranteed first year salary, plus malpractice insurance and other benefits. Contact J. K. Villegas, M. D., (217) 854-9664.

WELL ESTABLISHED PRACTICE general surgery and general practice looking for associate who will buy within six months to one year or right now. 40 miles from Chicago. Twenty years established practice, excellent income. Substantial income from hospital on trauma call. Reply to Box 2061, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS (Chicago, west & central areas): Seeking emergency medicine physicians for full time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1(800)253-1795, or in Michigan 1(800)632-3496.

PLASTIC SURGEON/DERMATOLOGIST or other surgical specialty to share luxurious Lake Point Tower office with established facial cosmetic surgeon. Includes new state-of-the-art office operating room with back-up recovery facility available. Complete facility and staff already functional. Please call Annette M. Hoffman, M.D.; (312) 222-0515.

RADIOLOGISTS NEEDED. Progressive 5 physician group is seeking two radiologists to join its expanding practice in upper Midwest. One position will assist the group in providing services to a large hospital and large multi-speciality clinic practice. Experience in all modalities is essential. The second position will provide general radiography, mammography and ultrasound for several small rural hospitals. Both positions offer attractive compensation and benefits along with the opportunity to practice high-quality medicine. Submit CV and cover letter explaining expectations to Box #2059, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FAMILY PRACTITIONER NEEDED For Midwest community. Close to several major cities. Free office and other incentives for the 1st year. Reply to Box #2060, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GULF COAST Beautiful Mobile Bay area—substantial guaranteed income with time to enjoy sunbelt lifestyle. BE/BC—family physicians, IM, or EM to join medical group with multiple urgent care/family practice clinics. Contact: Ms. Vogel, 1168 S. Beltline Highway, Mobile, Alabama 36609; (205) 343-5263.

FAMILY PRACTICE PHYSICIAN B.E./B.C. wanted. Senior member of well-managed two physician family practice corporation retiring August 1. Well established practice in south suburban Dayton, Ohio. Better-than-competitive salary, benefits, and profit sharing. Partnership opportunity. Ten physician co-op for night/weekend call. Satellite hospital 1.5 and teaching parent hospital 7 miles from office. Full specialty back-up. No obstetrics. On site laboratory and x-ray. Outstanding cultural, educational, and recreational opportunities including those in nearby Cincinnati with major league sports. Contact Verne H. Dodson, M.D., 1012 East Central Ave., Miamisburg, Ohio 45342. Phone: (513) 866-1012.

ILLINOIS—Seeking physicians for hospital based industrial medicine clinics. Directorship and assistant directorship available. Attractive compensation and malpractice insurance provided. Contact Emergency Consultants, Inc., 2240 S. Airport Road, Room 17, Traverse City, Michigan; (800) 253-1795, or in Michigan (800) 632-3496.

CARDIOLOGY: 56-MD multispecialty group seeking second cardiologist to associate in an excellent growing consultative practice, combining both invasive and non-invasive opportunities. Well equipped offices in a modern, accredited facility. Drawing area nearly 400,000 with two well-staffed, modern hospitals. Stimulating Midwest "Big-10" university community of 100,000 with superb cultural advantages. Ideal for family. Medical school teaching affiliation if desired. Excellent initial guarantee and fringes with early associateship and subsequent income based exclusively on productivity. Send C.V. to Box #2056, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS—Seeking physicians for hospital based industrial medicine clinics. Directorship and assistant directorship available. Attractive compensation and malpractice insurance provided. Contact Emergency Consultants, Inc., 2240 S. Airport Road, Room 17, Traverse City, Michigan; (800) 253-1795, or in Michigan (800) 632-3496.

INTERNIST WITH or without subspecialty to join busy, expanding internal medicine practice in North Georgia community, one hr. from Atlanta and one-half hr. from Athens. First year salary leading to partnership. Send resume to Box #2058, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

OB/GYN, ORTHOPEDIC SURGEON: Board certified or eligible to join 15 member group in progressive northwestern Wisconsin community. Modern, well-equipped hospital located adjacent to our facility. Close to Minneapolis, Eau Claire and Duluth, the Rice Lake area offers excellent educational, religious and community activities in addition to exceptional sports, hunting, fishing, and recreational opportunities. For more detailed information regarding our group, please contact Mark T. Nymo, M.D., Indianhead Medical Group, 1020 Lakeshore Drive, Rice Lake, WI 54868; (715) 234-9031.

STAFF PHYSICIAN. Anticipated opening July/August, 1987 for primary care internist, family physician, or pediatrician. Join staff providing medical service to college students. Full-time 10 or 11 month position. Competitive salary/benefit package and 40 hour week. Illinois license and board eligibility/certification. Contact Paul Nelson, M.D., Student Health Service, Illinois State University, Normal, Illinois 61761; (309) 438-8655. To assure consideration, please apply by May 15, 1987. Affirmative Action/Equal Opportunity Employer.

INTERNAL MEDICINE PGY-2 residency position available. MacNeal is a community based primary care hospital affiliated with Rush-Presbyterian-St. Luke's Medical Center. Residents rotate at both hospitals. Contact: Lawrence La Palio, M.D., MacNeal Hospital, Medical Education, 3249 S. Oak Park Ave., Berwyn, IL 60402; (312) 795-3400.

EMERGENCY DEPARTMENT Directorships, full-time and part-time opportunities available with Emergency Consultants, Inc. in Alabama, Illinois, Indiana, Michigan, New York, Ohio, Pennsylvania, Tennessee, Texas, Virginia and West Virginia. Guaranteed hourly rate and malpractice insurance provided. Contact Emergency Consultants, Inc., 2240 S. Airport Road, Room 17, Traverse City, MI 49684; (800) 253-1795, or in Michigan (800) 632-3496.

SITUATIONS WANTED

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box #2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED RADIOLOGIST, university trained, 10 years in practice, available for part time coverage of office, clinic, etc. after July 1 in Chicago area. Reply to Box #2049, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DIAGNOSTIC RADIOLOGIST: Board certified, interventional and imaging fellowships, experienced in all modalities, seeks locums short term. Available most weekends, some weeks including weekdays. Reply to Box #2051, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL PRACTICE WANTED: Physician wishes to buy existing general medical practice preferably in DuPage county or nearby. Call (312) 983-0773 after 7:00 p.m.

WANTED TO BUY. General practice or general practice with general surgery. Could take over the practice immediately. Reply to Box #2063, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED GENERAL Surgeon seeks suitable position. Willing to do some general practice. Will consider HMO and urgent care centers. Reply to Box #2062, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE, LEASE OR RENT

FOR RENT: Beautiful and well furnished office for rent for any specialty in growing area of Carol Stream, IL. Call (312) 830-3000 after 5:00 p.m.

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

SELLING FAMILY PRACTICE Southside. Grossing $125,000. Working 3 hours. More potential if fulltime devoted. Selling cheap with equipment. Relocating. Excellent office. (312) 333-6789 evenings/weekends.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)662-1664 or (312) 244-3357.

DES PLAINES. Medical suite in beautiful Lee Street atrium building. Waiting room, reception, offices, two exam rooms. Newly carpeted. Competitive rental plus attractive move-in bonus. Shaker. (312) 524-0800.

USED MEDICAL EQUIPMENT. Complete suites or individual pieces bought and sold. Also examination tables, O.R. tables, O.R. lights, EKG's, therapeutic and diagnostic ultrasound, diathermy surgical instruments, microscopes, etc. Please call or write Robert Shapiro at 2618 W. Peterson Avenue, Chicago, IL 60659; (312) 743-3900.

RENT SUBSIDY: General internist practicing in quaint cottage setting seeks pediatrician, OB/GYN, ortho., ENT, etc, to share space. Located in rapidly growing Lisle. Attractive terms negotiable. (312) 968-2735.

GENERAL INTERNIST. Invest in yourself! One suite remaining in new medical building with numerous specialties now represented. Located in university town in Dunes country of southern Lake Michigan, fifty miles from Chicago. Superior schools, many recreational opportunities, small town atmosphere. Join other physicians now in independent private practice. Achieve your optimum potential by beginning your own practice in this beautiful new building. Complete lab and x-ray. May invest in building or rental available with large subsidies for beginners. Three minutes from 400-bed hospital with all medical facilities. Contact: Thomas J. Covey, M.D.; (219) 462-4167.

FOR RENT: Medical/dental suite located in Hinsdale in prestigious professional building with elevator and spacious parking. 1200 square feet includes 6 rooms plus waiting room and business office. Excellent built-in cabinets, carpeting and tile; some furniture available. Lab, x-ray and pharmacy on premises. Available now at below market rate; (312) 325-6880.

MEDICAL OFFICES and suites available: Lincoln-Ashland-Belmont, Chicago, Illinois. 200-1200 square feet, professional building, elevator, full service janitorial staff, central heat & A/C. Gary Solomon & Co (312) 334-5400.

FOR SALE: Rechargeable Sonicaid OB Doppler, three years old; never been used. Still in case. $200. P.O. Box 290, Mt. Vernon, IL; (618) 244-6473.

FOR SALE: 30-year family practice grossing over $350K/year in central Illinois. Includes house, full office facilities, medical supplies and equipment. Retiring doctor willing to negotiate. Please send inquiries to Box 2055, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602; or call (312) 303-0043 after 6:00 p.m.

MISCELLANEOUS

PHYSICIANS—EMC*EXPRESS,™ General Electric's electronic medical insurance claim delivery service, is now available. Fully computerized accounts receivable management. Office Resources (815) 664-2567.

MEDICAL PRACTICE SALES and appraisals. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004; (215) 667-8630.

DISCOUNT HOLTER SCANNING Services starting at $35.00. Spacelabs holter recorder (cassette) available from $1275.00. Cardionostic holter recorder (cassette) available from $995.00. Smallest and lightest holters update. Fast service (24-48 hrs turn over). Hookup kits starting at $4.95. Special introductory offer of three free tests with any purchase or lease of the recorder. Cardiologist overread available for $15.00. If interested call (301) 870-3626.

MEDICAL TRANSCRIPTION: Federal disability letters, consultations, progress notes; 24 hour toll-free phone-in dictation service; fast turn-around time; fee per line. Certified Medical Transcriptionists (AAMT), qualified in all specialties. Hagedorn Secretarial Service, Inc., "Specialists in medical transcription"; (312)296-0034.

THINKING OF SELLING Your practice? We have cash buyers paying highest prices. Have your practice appraised by professionals. Call or write at no obligation. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

MEDICAL PRACTICE SALES. At Medidentic we have the expertise and the contacts to sell your practice. Buyers and sellers, see our ad on page 215. Medidentic Practice Sales—(312) 696-0220.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy, (312) 337-4221.

WANTED: ECG MACHINE; Phonocardiogram; Doppler Echo; Diathermy. P.O. Box 290, Mt. Vernon, IL; (618) 244-6473.

A Mentor, a Leader and a Conscience



Allan L. Goslin, M.D.
1936-1987

My friend and colleague, Dr. Al Goslin, died yesterday.

Many things come to mind at a time like this; Al's apparent heart attack while on vacation was a total shock. He was only 50 years old and in good health. He took office as president of the Society only three weeks ago. Just two days before his inauguration, Al took time to fly back to LaSalle County's monthly medical society meeting to serve as its secretary-treasurer.

Al was a natural leader, generous with his time and counsel. I know that he had many plans for Illinois medicine this year, and that his intellect and energy are irreplaceable. His mind was so sharp and his instincts so precise that we may never fully appreciate the extent of our loss.

Al Goslin loved life. His natural enthusiasm gave him an extraordinary sense of the potential in each individual. A multifaceted man, he was equally at ease piloting an airplane and fishing for bass. His passing is a challenge to each of us to meet a standard few can hope to fulfill.

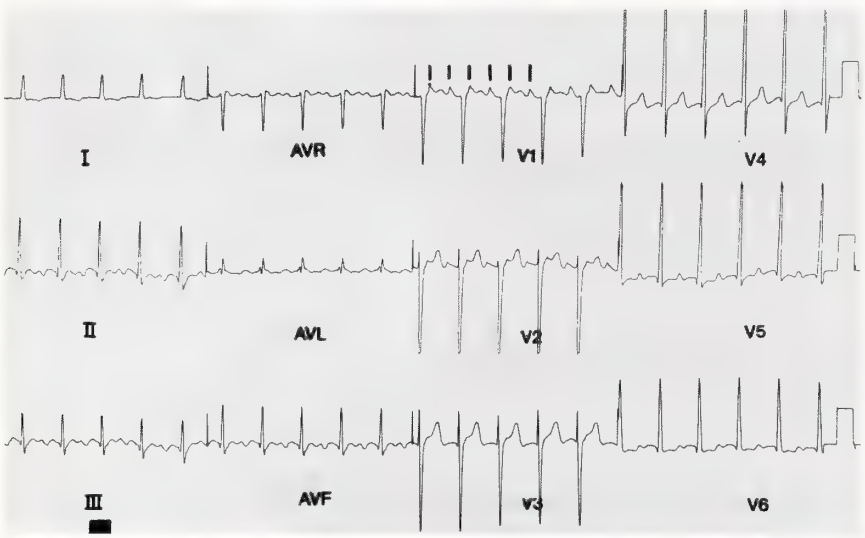
Al's inaugural address was a classic call to demand more of ourselves. His theme was unity, and he urged that physicians work together for the common good. "Stay unified as a profession," he said. "Enter the arena of community service and public speaking. Improve the quality of care by improving medical discipline. Reach out to colleagues and ask them to join with you as members of your county and state medical societies and the AMA. Help our younger colleagues. In addition to being a good clinician, be a caring, competent person, who spends time listening to your patients."

The Society's bylaws dictate that the first vice president succeeds the president in an event such as this, which means I am expected to fill his shoes. That is a tall order. I'll seek your forbearance as we work together to fulfill his vision. ◀

Edward J. Fesco, M.D.
May 4, 1987

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was a forty-one-year-old woman with a six-year history of chronic renal failure secondary to severe hypertension. She had a failed renal transplant surgery five years ago and was maintained on chronic hemodialysis. She also suffered from severe renal osteodystrophy following parathyroidectomy. During the past year, severe hypertension with cardiac arrhythmias had occurred during hemodialysis.

On the day of this twelve lead ECG recording, the patient had a generalized tonic-clonic seizure for several minutes during hemodialysis. There was no loss of pulse and blood pressure was recorded at 260/160mmHg. She temporarily lost consciousness. Her pulse measured 130 beats per minute. The lungs had bibasilar crepitant rales. The cardiac exam demonstrated an atrial (S_4) and a ventricular gallop (S_3) with a sustained ventricular impulse at the point of maximal impulse near the anterior axillary line, fifth intercostal space. All peripheral pulses were present and bounding. The seizure had stopped and the patient was conscious when the ECG was obtained.

Questions:

1. **This twelve lead ECG shows:**
   - A. Sinus tachycardia.
   - B. Atrial tachycardia.
   - C. Atrial fibrillation.
   - D. Atrial flutter with 2:1 atrioventricular (AV) block.
   - E. Left ventricular hypertrophy with ST-T wave changes.

2. **Which of the following answers are correct:**
   - A. This patient likely has a hypertensive encephalopathy.
   - B. Nitroprusside infusion might be helpful.
   - C. Hemodialysis ought to be continued.
   - D. Digoxin therapy with careful dosing and plasma concentration monitoring might be helpful.
   - E. All of the above.

(Continued on page 328)

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WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided during first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS—Observe usual precaution in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by John A. Lind, Jr., M.D., Department of Radiology, Loyola University Medical Center, Maywood, .

This 52-year-old man has a known diagnosis of Crohn's disease. He now presents with diarrhea, a right lower quadrant mass and fever.



Figure 1
Small bowel examination shows displacement of intestine in the right lower quadrant. (arrowheads) Image provided by Joseph Porada, M.D., St. James Hospital, Chicago Heights.

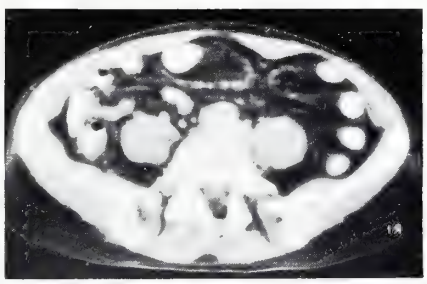


Figure 2
CT image at the same level as the displaced bowel. Image provided by Joseph Porada, M.D., St. James Hospital, Chicago Heights.

Your diagnosis?

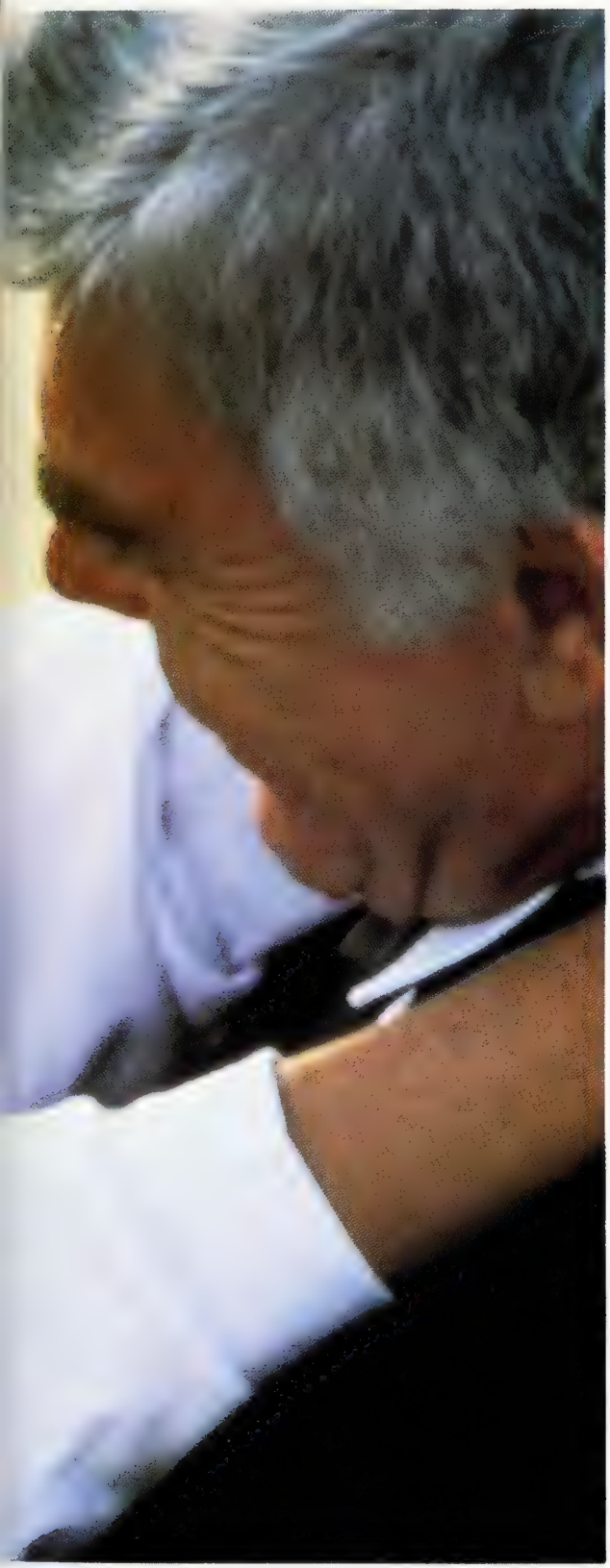
1. Phlegmon
2. Abscess
3. Fibrofatty proliferation
4. Mesenteric lymphadenopathy
5. Lymphoma

(Continued on page 322)

There's never been a better time for her..



ınd PREMARIN®



Proven benefits beyond relief of vasomotor symptoms

No other estrogen proven effective for osteoporosis

Only conjugated estrogens tablets have established efficacy in both osteoporosis[1] and vasomotor symptoms* at 0.625 mg/day. No other estrogen, oral or transdermal, has established clinical evidence or minimum effective dose in both indications.

No estrogen proven safer

PREMARIN is the most extensively tested estrogen, with an unsurpassed record of long-term safety.
And clinical evidence shows a significantly reduced risk of endometrial hyperplasia when cycled with a progestin.[2]

PREMARIN®
(conjugated estrogens tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms and for osteoporosis

PREMARIN®
(conjugated estrogens tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

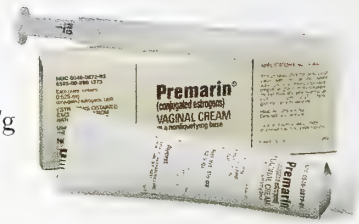
The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(conjugated estrogens)

Vaginal Cream

0.625 mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA
Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption, loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Osteoporosis: Female castration. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart DM, Clark DM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. **2.** Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause.* Lancaster, England, MTP Press Ltd, 1980, chap 13.

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Legislative Activity Stepped Up

As the pace in the Illinois General Assembly picks up, so, too, is physician activity, with respect to the legislative effort for additional malpractice reforms.

Face-to-face meetings between physicians and legislators are continuing in earnest. For example, four state representatives, and a state senator attended a special luncheon meeting at Alexian Brothers Medical Center in Elk Grove Village on Friday, March 27. Attending the meeting were: Sen. Virginia MacDonald (R-Arlington Heights); and Reps. David Harris (R-Arlington Heights); Bernard Pederson (R-Palatine); Terry Parke (R-Schaumburg); and Kay Wojcik (R-Schaumburg). Sen. Beverly Fawell (R-Glen Ellyn) also was represented at the meeting.

In a strong display of the widespread nature of support for continued reform, the meeting included the hospital's chief executive officer, its board of trustees chairman and the mayor of Elk Grove Village.

The session was organized by Dr. Dennis Brown, chairman of the physician action team at Alexian Brothers Hospital. Also attending was Dr. Alfred J. Clementi, immediate past chairman of the Illinois State Medical Society Board of Trustees. The physicians at the meeting indicated that lines of communication had been opened between the physicians and legislators on the issue of caps on awards for noneconomic damages and a revised statute of limitations for suits involving treatment of minors.

Also on March 27 a meeting was held at Resurrection Hospital in Chicago between the hospital's action team and Sen. Walter Dudycz (R-Chicago). A representative of Rep. Ralph Capparelli (D-Chicago) also attended.

Others at the meeting were the



Rep. David Harris addresses a meeting of physicians and hospital officials at Alexian Brothers Medical Center in Elk Grove Village as Rep. Terry Parke and Sen. Virginia MacDonald look on.

hospital's chief executive officer, as well as members of its governing board and its medical and nursing staffs. The meeting was organized by Dr. Tassos Nassos.

Senator Dawn Clark Netsch (D-Chicago) and Rep. Jesse White (D-Chicago) were the focus of separate meetings held at Augustana Hospital in Chicago on March 27 and April 3. Attending the meetings were physicians from the medical staffs of Augustana, St. Joseph, Children's Memorial and Grant Hospitals.

The sessions were organized by Augustana's action team leader, Dr. Barry Goldsmith. Also involved were the presidents of the three hospital medical staffs, Dr. William Dalessandro of Augustana, Dr. Marianne Larsen of Children's Memorial, and Dr. Franklin Schwartz of St. Joseph, as were representatives of Augustana's administration and governing board.



Rep. Bernard Pederson (left) discusses malpractice reform with Brother Philip Kennedy, chief executive officer of Alexian Brothers Medical Center.

Dr. J. Vega, former medical staff president, represented Grant Hospital.

Meanwhile, Dr. Jesse Waller of Augustana was instrumental in educating other physicians and the legislators about the detrimental effects of other legislation being considered by the legislature—that which would force physicians to accept Medicare assignment as a condition of licensure.

Representative White was hailed as a sponsor of the ISMS-supported reform legislation adopted during the 1985 session of the General Assembly. While Rep. White expressed support for further reforms, Sen. Netsch expressed her reservations about a cap on noneconomic damages. ◀

Malpractice Reform, Medical Practice Act Legislation Introduced

The Illinois State Medical Society's latest proposals for further malpractice reform were presented to the Illinois General Assembly on April 10. Also offered that same day was legislation that embodies the Society's suggested revisions to the state's Medical Practice Act.

In the Senate, S.B. 701 contains the revised statute of limitations for suits involving treatment of minors. The bill would reduce the current allowable filing time from as much as 22 years to a maximum of 10 years. It is sponsored by Senators Aldo DeAngelis (R-Chicago Heights), and William Mahar (R-Homewood).

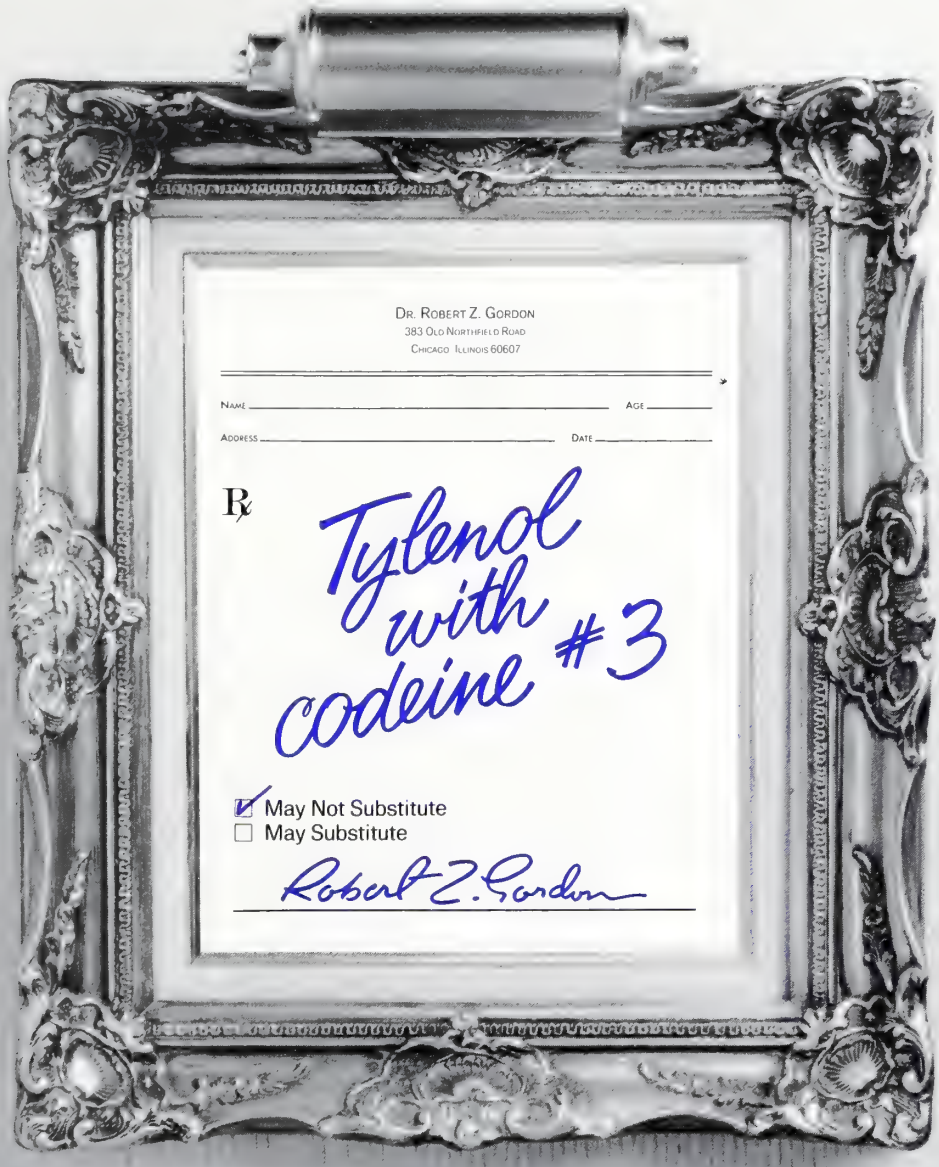
S.B. 807 would impose a $250,000 cap on awards for noneconomic damages (*e.g.*, pain and suffering) in medical malpractice cases. No limitations would be imposed for economic losses such as medical expenses and lost wages. S.B. 807 is sponsored by Sen. Bob Kustra (R-Des Plaines) and Sen. Mahar.

The revised Medical Practice Act is contained in S.B. 1309. Its chief sponsors are Senators Jack Schaffer (R-Crystal Lake) and James "Pate" Philip (R-Addison). Co-sponsors are Senators Stan Weaver (R-Champaign), John Davidson (R-Springfield) and Sen. DeAngelis. Among the changes proposed by the new legislation are several mechanisms to strengthen physician discipline. Most of those measures were offered by the special Task Force on Medical Discipline convened last year by Gov. James R. Thompson with the cooperation of ISMS.

In the House of Representatives, 21 Democratic representatives have agreed to sponsor the Society's proposed new Medical Practice Act. Chief sponsors of the legislation, H.B. 1933, are Reps. Alfred Ronan (D-Chicago), Carol Moseley Braun (D-Chicago), William J. Laurino (D-Chicago), Bruce Farley (D-Chicago), and Kurt Granberg (D-Centralia).

Other sponsors are Representatives Joseph Berrios (D-Chicago), Robert Bugielski (D-Chicago), Ralph Capparelli (D-Chicago), James DeLeo (D-Chicago), Frank Giglio (D-Calumet City), Gary Hannig (D-Mount Olive), Larry Hicks (D-Mount Vernon), Myron Kulas (D-Chicago), Ted Leverenz (D-Maywood), Richard Mautino (D-Spring Valley), Samuel Panayotovich (D-Chicago), James Rea (D-Christopher), Bruce Richmond (D-Murphysboro), Terry Steczo (D-Oak Forest), Robert Terzich (D-Chicago), and Jesse White (D-Chicago).

Sponsors of the House version of the legislation capping noneconomic damages (H.B. 1880) are Reps. Ronan and Tom Ryder (R-Jerseyville). Both representatives are also sponsoring H.B. 1881, which contains the revised statute of limitations. ◀



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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Authorization Denied

PAYMENT REFUSED

Cost containment is on everyone's mind these days. In response to the public objective of curtailing rising health care costs, new financing systems have emerged in both the public and private sector. For example: Medicare hospital reimbursement, formerly based on the cost incurred as determined *after* services were rendered, is now a prospective payment system founded on classifications of medical conditions called Diagnostic Related Groups. Federal policy also encourages the enrollment of Medicare beneficiaries in HMOs (Health Maintenance Organizations) and CMPs (Competitive Medical Plans) which negotiate "at-risk" contracts with the Department of Health and Human Services. A glimpse at health care financing in the private sector reveals dramatic changes as well.

In PPOs (Preferred Provider Organizations) insurers and other third party payors attempt to reduce their costs and those of their subscribers by entering into contracts with physicians, hospitals and ancillary providers who furnish services at a discount. In capitated delivery systems, such as HMOs, contract providers receive a fixed price to pay for all the health care services provided, regardless of patient utilization. Many employers have also established their own cost containment programs. Some focus on prevention of illness by tying mandatory annual checkups to well care health benefits. Others require a second surgical opinion to reduce the possibility of unnecessary surgery. Some replace expensive hospitalization with the use of less expensive facilities, such as extended care facilities, ambulatory surgery centers, hospices and home health.

New cost containment mechanisms go hand-in-hand with the new economic structures of alternative delivery systems. One mechanism, prevalent in HMOs and PPOs, is sometimes called **prospective utilization review, prospective review, prospective payment,** or **prior authorization.** Some observers believe the potential for harm is inherent in this utilization review system, while others view the system as the best and only way to contain costs. Many note that prospective review is profoundly affecting health care decisions. Regardless of the controversy about the effects of prospective review, one thing is certain: Prospective utilization review creates new responsibilities for the physician as the patient's advocate.

Because the system often hinges on the physician's contractual obligation to abide by the HMO or PPO utilization review decisions and procedures, one might assume that a good starting point in understanding the accompanying new responsibilities would be to examine the contract. This, however, is not the case. The contract establishes the legal and economic relationship between the physician and the business entity. The "standard of care" which defines the physician's duties to his or her patient remains the same regardless of the contract. The same "standard of care" applies to the physician's contract patients as applies to the physician's private patients. Perhaps the best way to understand the issues raised by prospective review is to discuss the conventional review system.

Traditionally, utilization review took place in the hospital, generally under the control of the medical staff. Utilization review was retrospective. It took place *after* care was rendered by examining the patient's chart to determine if the treatment provided was medically necessary. Some early cost containment programs also used "after the fact" or retrospective review. The third party payor reviewed the patient's chart to decide if, in its judgment, the care already rendered was medically necessary. If the reviewer found the treatment was not medically necessary, the claim was denied. In **prospective review,** the reviewer, be it a third party payor, HMO, PPO, or review organization, decides whether the care is medically necessary *before* care is rendered. In other words, authorization for payment is granted or denied *before* care is rendered.

In the *Wickline Case,* (California Court of Appeals) a summary of the problems inherent in prospective review were noted:

> The purpose is to promote the well-recognized public interest in controlling health care costs by reducing unnecessary services while still intending to assure that appropriate medical and hospital services are provided to the patient in need. **However, such a cost containment strategy creates new and added pressures on the quality assurance portion of the utilization review mechanism.** The stakes, the risks at issue, are higher when a prospective cost containment review process is utilized than when a retrospective review is used.
>
> A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in the prospective review process, in practical consequences, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death.

As one commentator succinctly stated: "Denial of claims is measured in dollars; denial of care in lives."

The added pressures on quality assurance inherent in prospective review flow directly to the physician. Medical care decisions are grounded on the treating physician's personal knowledge of the patient's condition and the patient's informed consent. In prospective review, third parties undertake decision-making roles before care is rendered. Contracts utilizing prospective review limit decision-making in a number of ways.

Generally, physicians are required to obtain prior authorization for diagnostic procedures, for referrals to noncontracting providers, for hospital admissions, and for continued length of stay prior to discharge. **However, the ethical and legal responsibility for the exercise of good medical judgment remains with the physician. It does not shift to the review organization. Equally important, the physician's "standard of care" is not diminished by cost containment programs.** In the *Wickline Case* the court stated:

> The physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.

The fact that a contract obligates the physician to comply with utilization review decisions, and penalizes those who do not, with either contract termination or financial sanctions, does not alter the physician's primary obligation to his or her patients. When a utilization review organization second guesses the treating physician's medical judgment, the responsibility for the medical decision does not shift to the organization, it remains with the physician.

In practical terms the refusal to authorize treatment generally means that the entity refuses to pay for it. To some it may appear that the system puts the physician between the proverbial rock and a hard place. But there are several actions physicians can and should take to protect their patients and themselves when the review organization denies authorization for recommended treatment. To address the pressures placed on quality assurance by review programs the informed physician follows two commandments: **Protest and Document.**

As one would imagine, prospective review procedures vary greatly. For a national network PPO you may begin the process by calling an 800-number and speaking to a reviewer hundreds of miles away who uses a computer software system. If you belong to a local IPA the reviewers may be familiar to you and you may be well-accustomed to the procedures. Most review programs do, however, have more than one level of review so that you can appeal a decision which denies authorization for care which you have recommended. Using all the procedures available, the informed physician vigorously protests denials. If the denial stands at the second level of review and there is a third level to protest the denial, the informed physician uses it. Generally speaking, a good rule is to follow the procedures stated in the contract and exhaust all the procedures available under the contract.

As each protest is lodged, the informed physician documents the dispute and the steps taken to resolve it. The patient is informed of the physician's recommendation and of the risks involved if that recommendation is not followed. The physician also tells his or her patient that the plan is against the recommended treatment and that the patient may be liable for payment if treatment is received without plan authorization. This information is noted in the patient's chart and in letters sent to the review organization and the patient.

Because you're an informed physician, who recognizes the complex issues involved in contracts for the delivery of medical care, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you objective comments on any HMO, PPO or IPA contract at no cost. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Public Health (IDPH)

Proposed Rules for Designation of Trauma Centers

The IDPH has submitted for public comment proposed rules for the designation of Trauma Centers in Illinois (outside Chicago). The draft rules provide, among other things, for a single Level I Trauma Center for each designated Trauma Region of 600,000 population. Subregions will be created in areas where the transportation of a trauma patient to the Level I Trauma Center would take longer than 30 minutes.

Where subregions are created, the proposed rules provide for one Level II Trauma Center in each subregion. The IDPH will make its Level I and Level II Trauma Center designations among those hospitals that demonstrate the highest level of substantial compliance with the requirements proposed in the regulations.

In addition, the proposed rules provide for "Affiliate Trauma Hospitals" to be part of the Trauma Region. An "Affiliate Trauma Hospital" is defined as "a hospital that provides initial trauma care in accordance with a cooperative agreement with a Level I or II Trauma Center for the provision of those services."

Persons wishing to comment on the proposed rules may submit comments or testify at one of the following scheduled hearings:

5/26/87-10:00 a.m.
Conference Center, SIU-Carbondale Student Center, Mississippi Rm., Carbondale, IL 62901.

5/28/87-11:00 a.m.
Hampton's Walnut St. Landing, Appaloussa Rm., 1701 N. Walnut, Springfield, IL 62702.

6/1/87-11:00 a.m.
Illinois Hospital Association, Center for Health Affairs, 1151 E. Warrenville Rd., Naperville, IL 60566.

(Source: IDPH Notice of Proposed Rulemaking)

From the Department of Registration and Education (DRE)

Medical Discipline Orders

- *Frank Boon* (lic. # 036-044571)
  Effective May 4, 1987, Dr. Boon's medical license is suspended for a six month period.
- *Luisito A. Evangelista* (lic. # 036-037788)
  Effective March 25, 1987, Dr. Evangelista's medical license was suspended for a period of 45 days, followed by the imposition of a probationary period.
- *James B. Hurd* (lic. # 036-027110 & 003-036-027110-1)
  Effective February 19, 1987, Dr. Hurd's medical and controlled substance licenses were indefinitely suspended.
- *Brian R. Molstad* (lic. # 036-062009)
  Effective March 25, 1987, Dr. Molstad's medical license was suspended for an indefinite period, but the suspension was stayed and the license placed on probation, subject to certain conditions.
- *Patrick M. Riordan* (lic. # 036-048071)
  Effective March 30, 1987, Dr. Riordan's medical license was suspended for 30 days and subsequently placed on probation for a minimum of two years, subject to certain conditions.
- *Michael D. Smalkin* (lic. # 036-068685)
  Effective February 19, 1987, Dr. Smalkin's medical license was revoked.

(Source: Orders received from DRE)

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171 Cases Reviewed

Eosinophilic Fasciitis

By Eugene B. Loftin, III, M.D./Elgin

This patient's case may be considered typical of eosinophilic fasciitis. Domestic and available foreign literature are summarized as to clinical and laboratory manifestations, histopathology, response to treatment and natural course.

Early cases of the syndrome presently known as eosinophilic fasciitis (EF) were not recognized as a distinct clinical entity. Rather, they were given a name, such as "sclerodermodermatomyositis," treated with steroids and lost to follow-up as they improved dramatically.[1]

In 1974, Lawrence E. Shulman, M.D., first proposed that the presentation of diffuse fasciitis with hypergammaglobulinemia and eosinophilia was a distinct syndrome.[2] The characteristic laboratory findings included elevated erythrocyte sedimentation rate (ESR), peripheral eosinophilia and hypergammaglobulinemia. Tissue confirmation was by full thickness skin and fascia biopsy, demonstrating relative sparing of the skin and marked thickening of the fascia with perivascular infiltration of lymphocytes and plasma cells. These characteristics, plus a history of onset of symptoms in autumn, and recent exercise unusual for the patient, as well as marked clinical response to steroids, seemed to set this presentation apart from progressive systemic sclerosis. Rodnan *et al.*, reported first a series of seven, then an additional six patients, noting eosinophilic infiltration of the fascia, thus generating the name "eosinophilic fasciitis" (EF).[3,4]

Since that time, the pathogenesis of this syndrome has remained unclear, and separating it from other conditions of unknown etiology has become increasingly difficult. In part, this lack of clarity has been due to the small number of patients reported; the largest series numbered 20 case reports.[5]

The literature has blossomed to more than 171 cases *clearly* diagnosed since EF was first described 12 years ago. This count is based on review of 101 articles from the domestic and foreign literature. Additional foreign articles are known to exist, and likely contain reports of other cases, but were unavailable for review and not counted here. The individual cases were reviewed to determine that no overlap existed as to patients in other reports, and that the diagnosis of EF was satisfactorily proven. Only 10 patient case reports were rejected on this basis. This larger body of literature presents the opportunity to more precisely describe and categorize EF as a clinical entity.

The following is a report of a case representative of the syndrome.

Case Report

A 24-year-old white woman presented as an outpatient with two weeks' swelling of her arms distal to the elbows and legs distal to the knees. She had periorbital edema, decreased grip strength bilaterally, and diffuse arthralgias. The patient related onset of these symptoms to painting and general clean-up around a new house that she and her husband were building.

There was no recent contact with potential toxins. She did have a history of nonspecific arthralgias and myalgias, including a two week episode a year earlier of sharp chest pains after doing heavy work at a local grocery store. That episode responded to muscle relaxants and analgesics. Also that year, the patient had had an arthrocentesis of her right knee with removal of a

"large amount" of joint fluid.

A general review of systems was negative, aside from frontal headaches, "dizziness" when she varied from her hypoglycemic diet, and recurrent lower abdominal discomfort associated with some constipation. In particular, there was no history of alopecia, dermatitis, sun sensitivity, Raynaud's or Sjogren's syndrome, dysphagia, or menstrual irregularity.

Physical examination showed a well-looking white female, height 5 feet 1 inch; weight 128 pounds; blood pressure 108/74mmHg with a heart rate of 88 beats per minute. Examination of the head showed periorbital edema. Her fundi were benign and conjunctiva were clear. Ear, nose and throat examination was normal. Thyroid showed no thickening, enlargement or nodularity. Her lungs were clear to auscultation and percussion and breasts were symmetrical with no masses. Cardiovascular examination showed no extra sounds or murmurs. Examination of the patient's abdomen showed no organomegaly or tenderness. Her hair was normal. Examination of her integument showed slight digital pulp erythema and minimal palmar erythema. There was no periungal erythema, and capillary microscopy showed no abnormalities. Bilateral puffiness of hands and fingers was found extending up into the forearms, with similar findings in the feet and legs, particularly on the left. Her skin was not tethered; knuckle creases were all visible. There was no evidence of nail fold infarcts. Examination of joints revealed some tenderness and synovitis in the proximal interphalangeal and metacarpal joints diffusely and symmetrically, and range of motion was decreased bilaterally in the wrists. Her elbows were normal. There was some pain on range of motion of her shoulders, but motion was normal. She had bilateral acromioclavicular tenderness to palpation. Her temporal mandibular joints were normal to examination, although there was some discomfort on movement. Examination of her cervical spine was normal, as were dorsal and lumbar spine. There was marked tenderness over her paravertebral and gluteal muscles to palpation, although range of motion of her back was normal, as well as range of motion of hip joints.

There was bilateral increased temperature and slight erythema over both knees with some pain on range of motion, but mobility was normal. Examination of her ankles showed increased temperature bilaterally, with normal flexion and extension, but inversion and eversion were slightly decreased bilaterally, with slight midfoot tenderness to palpation on the left. No metatarsal phalangeal or interphalangeal tenderness was evident, but the patient did have some plantar tenderness bilaterally, particularly at the heel. Grip strength had decreased bilaterally and symmetrically. Her cranial nerves were all intact and symmetrical. Deep tendon reflexes were symmetrical, equal, but depressed.

A preliminary collagen vascular evaluation included automated chemistry profile showing calcium of 8.3mg per decaliter (dl) (8.6-10.8 being normal) associated with total protein of 5.5 grams/dl (6.8 being normal), and an albumin of 2.8 grams/dl (3.5-5 being normal). Complete biood count (CBC) showed hematocrit was 37.1%; hemoglobin 13.0 grams; white blood cell (WBC) count was 7,117 per cubic millimeter (cmm); red blood cells were 4.29 × 106/cmm. Differential WBC count was 25% eosinophils; 52% segmented leukocytes; 20% lymphocytes; 3% monocytes. Electrolyte panel was normal as was T4. The antinuclear antibody was negative.

The creatinine phosphokinase, Ch 50, C-3 and C-4 were normal. There were no extractable nuclear antigens. Upper gastrointestinal x-rays and small bowel follow-through to the terminal ileum were normal, as was the lower gastrointestinal series. Chest x-ray and x-rays of her hands were also normal. ESR was 10mm/hour, and rheumatoid factor was negative. Her urine was normal and a repeat CBC demonstrated 39% eosinophils. Repeated stools for ova and parasites were all negative. A c-reactive protein test was positive 1:2. Fibrinogen level was normal and a purified protein derivative skin test was negative with a normal mumps control. Quantitative immunoglobulins were within normal limits.

On the basis of the clinical presentation, a presumptive diagnosis was made of EF. Consultation was made for a muscle, skin and fascia biopsy, which was done of the left distal anterior leg compartment. The biopsy showed the typical marked fasciitis, and perivascular mononuclear infiltration of cells. As the patient was reluctant to accept steroid therapy, she was begun on oral cimetidine 300mg four times a day and fenoprofen calcium every six hours. No improvement was shown over the next two weeks. At that time, she agreed to a tapering course of prednisone starting at 60mg per day. The patient improved rapidly, but incompletely, with this treatment, and displayed persistent inability to make a firm fist even after one year. She reports no residual complaints or findings three years later.

Clinical Manifestations

After review of 171 clearly diagnosed cases from the literature, the EF male to female ratio is 1.3/1.0. Age ranges from 4-88 with an average of 43 years. All but four patients to date have been white; two were black and two Oriental.[5-8] Slightly more than half the patients reported onset of symptoms after vigorous exercise. The duration of symptoms prior to diagnosis ranged from one week to two years, not counting those diagnosed retrospectively.

Patients typically experienced diffuse swelling and stiffness with symmetrical involvement, though occasional unilateral onset has been seen. EF primarily affects the distal extremities with occasional synovitis or associated fever. Contractures, reported in 85% of cases, are not always relieved with treatment and time. Involved skin has been clinically described as dimpled, resembling the surface of an orange, to indurated and bound down subcutaneous tissue distinguishable from scleroderma. As stated by Dr. Shulman, "One can help to distinguish between these two disorders (EF and scleroderma) by trying to wrinkle the skin in an area where the skin is bound down. The fine wrinkling of the skin is preserved in EF;

in scleroderma the skin is bound down and cannot be wrinkled."[9]

Occasional associated conditions include carpel tunnel syndrome, which occurred in 22 (13%) patients. Sixteen (9.4%) patients have had severe hemotological disorders.[6,10-13] Four patients have had Raynaud's phenomenon and two have had Sjogren's syndrome.[6,14] Six patients have had associated disorders of the thyroid.[9,12,15-17] One patient later reported cystadenoma of the ovary.[16]

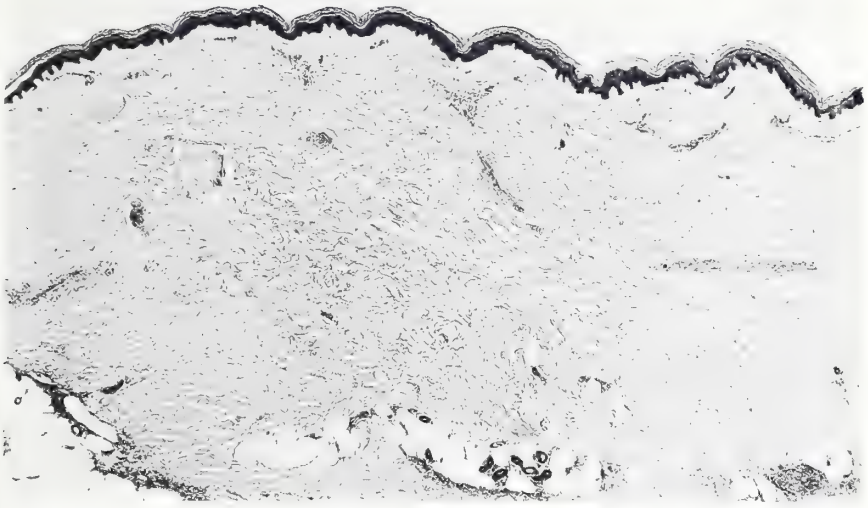


Figure 1
Low power view of continuous sagittal section of left distal anterior leg compartment biopsy. Note sparing of dermal and epidermal structures.

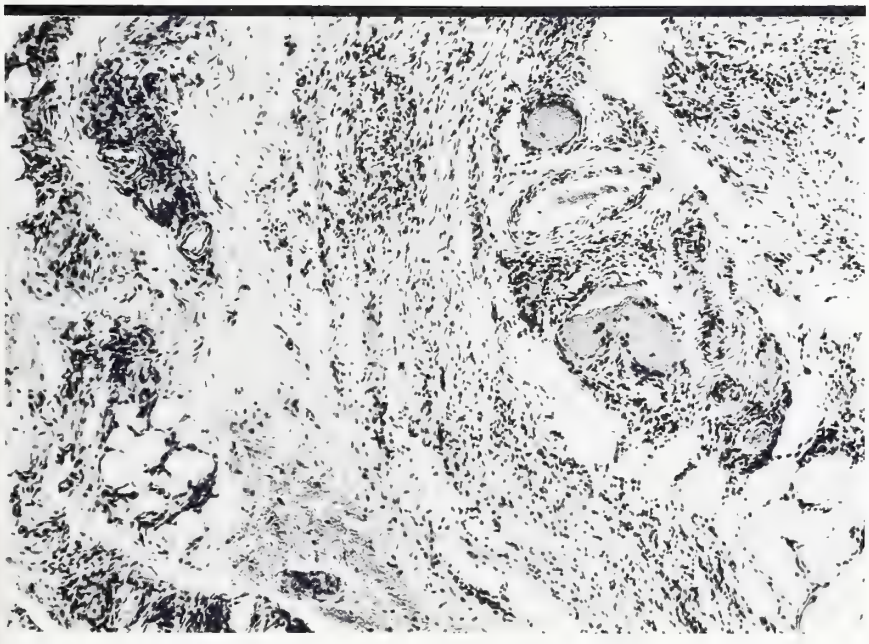


Figure 2
High power view of thickened fascia with mononuclear infiltrate (particularly perivascular).

Laboratory Manifestations

Peripheral eosinophilia was reported in 92% of cases. Peripheral eosinophile counts ranged from 4%-53% with an absolute count up to 9,434 per cubic millimeter.[5] Hypergammaglobulinemia has been documented in 65% of the patients. An antinuclear antibody was found in 25%, and when present, is usually in titers of 1:20 or less, with speckled or homogeneous patterns. The highest titer reported was 1:320.[19] Rheumatoid factor has been present in 13% of patients, with titers ranging from 1:64 to 1:1280.[12,19] Anti-DNA antibodies have been reported in three patients, but no patients have been reported with positive lupus erythematosis preparation or an abnormal compliment study.[6,12,17] Raji cell radioimmunoassay was shown to correlate best with disease activity among laboratory parameters evaluated in a study of 22 patients.[15]

Histopathology

Fasciitis is the common denominator of these patients. In all cases the fascia was thickened, edematous and/or inflamed with perivascular mononuclear infiltrate of plasma cells, lymphocytes and histiocytes. Eosinophils were noted in the infiltrate of the fascia in 58% of the cases reviewed. Muscle or dermal involvement was reported in 36%. Immunofluorescence showed no common pattern and was completely negative in 52% of cases. The ultrastructural aspects of biopsy material have also been studied, but no common denominator was found.[8]

Treatment and Course

Prednisone has been shown to be the drug of choice in the majority of patients. Improvement is often incomplete with residual skin changes or contractures. Relapse after withdrawal of corticosteroids has been occasionally reported.[6,12,13,16] Spontaneous remissions have also been reported.[6,10,12] Many other drugs have been tried in EF; none have been shown to be as efficacious as prednisone, although anecdotal findings suggest other

drugs may be useful. The spontaneous remissions make evaluation of these other drug regimens more difficult.

Differential Considerations

Some authorities suggest that EF is a subset of the morpheae. However, the clinical presentation and response to corticosteroids sets EF apart from those and other conditions affecting the extremities and associated with peripheral eosinophilia.[1] In dermatomyositis, muscle pain and weakness are seen as well as periorbital and Gottron's (atrophic) rashes. EF has not been associated with myopathy.

Most authorities consider EF as a separate clinical entity. The separation rests on the full thickness skin to muscle biopsy. Progressive systemic sclerosis lacks the deep fasciitis with perivascular infiltration of mononuclear cells typical of EF. Thickening of the dermis and atrophy of the dermal appendages are conversely not seen in EF. Visceral involvement is almost never seen, and the course of EF is generally benign with a good response to corticosteroids.

Capillary microscopy has also been shown to differentiate the two conditions. In that study, capillary microscopy was normal in 16 of 19 patients (84%) with EF, as it was for our patient. This contrasts to 11 of 13 (85%) abnormal in patients with scleroderma.[20]

Telangiectases and digital ulcers are often seen in scleroderma; they are not found in EF. An astute clinician should be able to distinguish between these two diseases solely on the basis of careful examination of the extremities.[9]

Conclusion

EF can be described as a distinct clinical entity whose pathogenesis remains under study. It is impossible to say at this time whether EF represents a primary process or whether other associated conditions such as hematologic and thyroid disorders stem from the same underlying disorder. The latter seems more likely.[10,12] Other authors suggest that EF is an intermediate disease with the same relationship to progressive systemic sclerosis that mixed collagen vascular disease has to systemic lupus erythematosis, *i.e.*, a more benign, steroid-responsive, closely-related but separate entity.

The classic description of a symmetric inflammatory induration of the arms and legs with a likely history of prior heavy exercise and an associated eosinophilia and hypergammaglobulinemia is still valid. Differentiation of EF from other conditions rests on the full thickness skin-to-muscle biopsy, although other parameters (close examination of the skin and capillary microscopy) allow a clinical diagnosis. This was the case in our patient. Contractures are the most common finding; carpel tunnel syndrome, synovitis or thyroid disorders are occasionally associated. Hematological disorders likewise occur only occasionally, but their association raises the concern that EF is a potentially malignant disease.

It is probable that EF is often mislabeled, as this condition generally improves with steroid treatment to the patient's satisfaction. AS EF is probably underdiagnosed, the literature may not reflect its true incidence, but studying samples from the literature gives the clinician a more clear picture of the syndrome. ◀

Acknowledgement

This large body of literature for review was collected through the efforts of two people, Anne Herron, M.D., St. Louis, and Richard Illgen, II, Bartlett.

The efforts of Mrs. Patricia Weber and Mrs. Marjeana Parrent of Fairfield, Illinois are also appreciated.

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With Carcinoma of Undescended Testis

Noonan's Syndrome

By Krishnan Sriram, M.D., Korathu Thomas, M.D., and Ronald Barnes, M.D./Chicago

A case of Noonan's syndrome with a malignancy developing in an undescended testis is reported. This is believed to be the first case of such an association reported in the English literature.

Noonan's syndrome was first described in 1968.[1] These patients have characteristic facies: ptosis; antimongoloid palpebral slant; broad, flat nose; webbed neck; high arched palate and malformed ears. They are usually of short stature, and frequently have congenital cardiac anomalies, most often pulmonic stenosis secondary to a dysplastic valve. Pectus excavatum or carinatum, cubitus valgus, undescended testis, impaired mental development, and recurrent chylothorax are commonly found. In both sexes, the karyotype is normal, and gonadal differentiation is consistent with the chromosomal and phenotypic sex. No metabolic, endocrine, or chromosomal abnormality has been discovered to date. The basic underlying defect remains unknown.

In 1982, many years after the incident, a case of an 11-year-old male child with Noonan's syndrome and spontaneous chylothorax was reported.[2] Mention was made in that article of "atrophic testes," but no supporting studies were reported. The case presented here is the same patient; he presented to another institution in 1982, 11 years later.

Case Report

A 22-year-old Hispanic male with Noonan's syndrome presented with abdominal pain of ten days' duration associated with malaise, easy fatigue, and vomiting. The pain was located in the right lumbar region, radiating posteriorly to the right flank. It had been increasing in severity since onset.

Physical examination revealed a young man who appeared to be younger than his stated age. He exhibited all the classic signs of Noonan's syndrome. Vital signs were normal. Height was 122cm and weight, 32.6kg. There was dullness to percussion and decreased breath sounds over the right lower lung field. A grade 3/6 holosystolic murmur was heard over the left sternal border radiating to both sides of the neck. Abdominal examination revealed a firm, nodular mass in the right lower quadrant, measuring 8cm × 6cm, with ill-defined lateral and inferior margins. Rectal examination was unremarkable. The scrotum was not developed. Neither testis was palpable, in the scrotum or the inguinal canal.

Pertinent laboratory data included elevated beta-HCG (patient 280m/U, normal 0) and alpha-fetoprotein (patient 746Ng/ml, normal 25Ng/ml). Liver function tests were normal. Sonogram of the abdomen showed that the right kidney was displaced by an 8 × 6 × 14cm mass in the right paracolonic gutter with abnormal rotation of the right kidney. There was no retroperitoneal adenopathy, and the liver was normal. Intravenous pyelogram revealed good bilateral renal excretion. Chest x-ray revealed prominent pulmonary vasculature and a right-sided pleural effusion.

Surgery

Tumor of an undescended right testis was the clinical diagnosis. At laparotomy, a large mass was noted anterior and lateral to the right kidney, extending to the internal inguinal ring. The mass involved the psoas muscle and Gerota's fascia. Although the mass was excised as completely as possible, there was definite gross involvement of adjacent structures. The patient's poor general condition precluded more extensive resection. Also, a normal-appearing intra-abdominal left testis was removed and a few left paraortic lymph nodes were biop-

sied. A needle biopsy was taken from the right lobe of the liver. Histopathology revealed poorly differentiated embryonal cell carcinoma of the right testis, with no evidence of lymph node or liver metastases (Stage I).

associated with hepatomegaly. Abdominal ultrasound and a CT scan of the abdomen revealed multiple space-occupying lesions in the liver. All tumor-markers were elevated. (Table 1)

Chemotherapy was changed to

Table 1
Tumor-Marker Levels During Therapy

Date	Beta-HCG	Alpha-FP	LDH	Temp.	Miscellaneous Information
12/82	280	746	1300	↑	Preoperative levels
1/83	3300	1000	1425	↑	Low dose chemotherapy
2/83	—	—	218	N	
4/83	3400	496	1400	↑	High dose chemotherapy
6/83	2.3	25	251	N	
8/83	—	—	—	—	Last dose of chemotherapy
9/83	4.1	25	176	N	
11/83	2.7	—	174	N	
2/84	4.3	4.5	183	N	
5/84	0	—	134	N	
9/84	4.9	—	139	N	
1/85	2.7	6.2	129	N	
4/85	3	6.5	139	N	

Key
Beta-HCG: Beta Human chorionic gonadotrophin (Normal 10mIU/ml)
Alpha-FP: alpha fetoprotein (Normal 25mg/ml)
LDH: Lactic dehydrogenase (Normal 100-225 U/L)
Temp: Temperature
N: Normal

Postoperatively, the patient's beta-HCG remained persistently high, as did his alpha-fetoprotein. (Table 1) Four weeks after surgery, the patient was readmitted for fever. Beta-HCG, alpha-fetoprotein and LDH levels were markedly elevated. Chest x-ray and liver function tests showed no change from previous results. Combination chemotherapy was started a month after surgery. The first day's treatment included cyclophosphamide 600mg/M^2, vinblastine 4mg/M^2, and actinomycin-D 1mg/M^2. In addition, 120mg/M^2 of cis-platinum was given on the seventh day. Only 50% of the calculated dose of chemotherapy was given because of the patient's poor general condition.

In April, 1983, after three monthly courses, the patient was admitted again, because of fever

monthly vinblastine 0.2mg/kg on days one and two, cisplatin 20mg/M^2 on days 1-5 and bleomycin 30mg on days two and nine. He tolerated full doses of this regimen fairly well, except for mild pancytopenia after each course. There were no major complications. A repeat liver profile five months later revealed that the patient's liver enzymes and tumor markers had returned to normal. Ultrasound examination showed no evidence of metastatic disease. The patient is alive and well two and a half years after initial surgery, with no clinical or biochemical evidence of recurrence.

Comment

Noonan's syndrome, or "Male Turner syndrome" has been applied to phenotypic males with certain anomalies which also occur in females with Turner syndrome. These boys have normal karyotypes. Males frequently have cryptorchidism[3] and small testes that may be hypogonadal or normal.[3] The cause is not known.

The relationship between cryptorchidism and testicular cancer has long been recognized and studied extensively.[4]

Our patient, with Noonan's syndrome and Stage I embryonal cell carcinoma in an undescended abdominal testis, had persistently elevated tumor markers postoperatively. He was treated initially with small doses of vinblastine, cyclophosphamide, actinomycin-D and cisplatin because of his frail nature. Subsequently, because of tumor progression and metastases to the liver on suboptimal chemotherapy, he was started on a full dosage of vinblastine, bleomycin and cisplatin.[5]

Repeat liver function tests and tumor marker determinations then returned to normal. Except for significant bone marrow suppression and febrile reactions following the first course of chemotherapy, the patient tolerated subsequent treatments well with only mild myelosuppression. The patient's long-term prognosis awaits further observation and follow-up.

To the best of our knowledge, this is the first case of embryonal carcinoma developing in an undescended testis of a patient with Noonan's syndrome. The case also illustrates the importance of administering full doses of chemotherapy. Even though toxicity of the higher doses of chemotherapy may be expected to be more severe, the chance of survival is nevertheless dependent on optimal therapy. The added toxicity is well worth the risk. ◀

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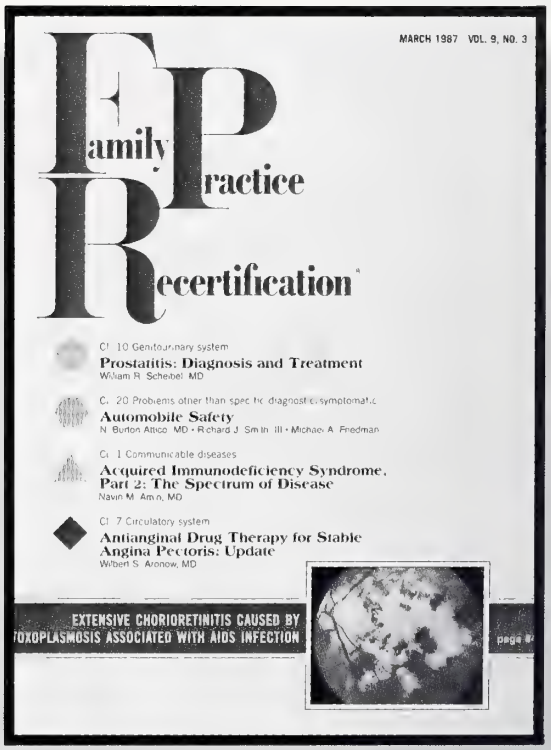
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In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

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New Law to Increase Organ Donations

The number of organ and tissue donations may be increasing dramatically due to a new Illinois law that took effect January 1. Under the Illinois Organ Donation Request Act, hospital personnel now must routinely ask the next of kin of patients who die in hospitals to donate the decedent's organs and tissues for transplant.

Impetus for the new law came from passage of similar laws in other states and efforts by Congress to adopt federal laws to encourage organ donation.

States with similar statutes in place have seen many more donor organs become available. Oregon, for example, has experienced a twofold increase in the number of corneas donated for transplant, and a 100% increase in the number of hearts, kidneys, and other organs.

The new Illinois law pertains only to facilities with more than 100 beds. However, as of July 1, the federal government will require *all* hospitals receiving Medicare and Medicaid funds to have established protocols for informing families about the option of organ and tissue donation.

The Joint Commission on Accreditation of Hospitals also is developing new standards which will require such protocols.

The Illinois law mandates that, when a hospital inpatient dies, the facility's administrator or his or her designee shall make a request for a donation from the next of kin. Requests must be made of the "highest priority" relative.

Priorities are defined (in descending order) as spouse, adult son or daughter, parent, adult brother or sister, and guardian. An organ or tissue gift cannot be accepted over the objection of a relative of the same or higher priority.

The Illinois law also defines certain circumstances in which a request need not be made:

- ☐ The decedent already had executed an anatomical gift card;
- ☐ The hospital is aware of opposition to such a gift by the decedent or any relative in the highest priority class;
- ☐ There is reason to believe that an anatomical gift is contrary to the decedent's religious beliefs; or
- ☐ The Illinois Department of Public Health has indicated that the need for organs and tissue for donation has been adequately met.

Specific procedures for making requests were not included in the Illinois law to give hospitals some flexibility in carrying out the law's intent while remaining sensitive to the concerns of the family.

Enforcement provisions also were left out of the new law, although legislators have indicated they are prepared to pass additional legislation should hospitals fail to conform to the intent of the current law. ◂

Organ Transplantation

Olga Jonasson, M.D., was appointed chairperson of the Task Force on Organ Transplantation by then-Secretary of the U.S. Department of Health and Human Services Margaret Heckler. The Task Force was created upon passage of Public Law 98-507, the National Organ Transplant Act.

Since Illinois' new "required consent" law was, in part, due to recommendations contained in the report of the Task Force issued last year, IMJ *sought an interview with Dr. Jonasson on this important subject. The text of that interview follows.*

A transplant surgeon, Dr. Jonasson is professor of surgery at the University of Illinois College of Medicine. This fall she will assume the post of chair of surgery at The Ohio State University, Columbus, Ohio.



IMJ: *Dr. Jonasson, during the past two years, you chaired the federal government's Task Force on Organ Transplantation. What was the impetus for formation of the Task Force?*

Dr. Jonasson: The public interest in transplantation came about parallel with a number of events that were occurring.

Transplantation was becoming more successful, therefore it was becoming more visible. It was something that now appeared to be a truly life-saving modality, and patients wanted it.

Similarly, there was some suspicion that, in order to get it, you had to be in a certain place at a certain time or have a lot of money, and that there was favoritism shown.

The costs are high, and that was a prominent issue as well. Allegations were made that perhaps there was some commercialization of organ transplant activities.

All of this combined to cause enough interest in Congress that a bill was proposed and signed into law by the President in October 1984. The new law did three things: (1) it created the Task Force to study a number of these issues and make recommendations; (2) it made commercialization of transplantation a felony; and (3) it directed that a national network of organ sharing, organ procurement and transplantation be formed.

IMJ: *As a transplant surgeon yourself, what is your perspective on how transplantation has progressed over the past decade?*

Dr. Jonasson: Actually, we're only about 30 years old as a specialty. And the first 15-20 years of that time was really a learning curve.

There was a lot that we needed to learn about immunosuppression, because it has so many risks to the patient associated with it. It has only been in the last decade that we've made real progress in organ transplantation, with mastery of the immunosuppressive drugs. Five years ago, we got a new drug, cyclosporine. And that has just transformed transplantation.

In 1966 or so, the one-year mortality for kidney transplantation was 30 percent. Now it's under five percent. And the success rate is now in the 80 percent range for unrelated cadaver donors.

Meanwhile, heart transplantation has a one-year success rate that's in the high 80 percent range. Heart-lung transplantation is successful. Liver transplantation is successful now. And much of that is due to cyclosporine.

IMJ: *So transplant surgery has seen some great success. But what do you see as its future?*

Dr. Jonasson: Well, it's not going to increase indefinitely. There's a clear limitation to organ transplantation, and that is the number of donors that are available and the timeliness of their donations.

For kidneys, that's less of a problem, because patients can be maintained on dialysis treatments. But for hearts or livers, where there's no means of maintaining the patients, it's life or death. And so the organ donor must be available when it's needed. Having them all come in July or August doesn't help most of the patients. There needs to be timely supply.

IMJ: *The shortage of donor organs has been a subject of concern for some time. But are there sufficient numbers of donors available?*

Dr. Jonasson: We believe that there are probably around 25,000 possible organ donors in this country every year . . . people that would meet the criteria to be an organ donor—brain dead people—people who have been in accidents or had some other catastrophe. Of them, we get approximately 4,000 organ donors in this country. There's a large gap there.

IMJ: *What can be done to reduce this gap?*

Dr. Jonasson: We're anticipating that this gap will be narrowed by better education of the public and by implementation of required request or routine inquiry laws. *(Editor's Note: See story on page 300.)*

If you survey the American public, you find that most people favor transplantation. *(Editor's Note: See story on page 308.)* They're familiar with it, and they feel that organ donation is a good thing to do. So if they're asked, most people would give permission for a family member to be an organ donor, or would sign a driver's license card to be a donor themselves.

There's a clear limitation to organ transplantation, and that is the number of donors that are available and the timeliness of their donations.

The reason that there's this wide discrepancy between what's available and what's obtained is largely because the families aren't asked. They're never given the opportunity to give the gift. We're hopeful that these routine inquiry laws will make it possible on a regular basis for families to be offered the opportunity to give.

IMJ: *In potential organ donation situations, how is the donor identified? Whose responsibility is it?*

Dr. Jonasson: Before we had the routine inquiry procedures, it was the nurse's or the physician's responsibility to carry the ball. They would have to approach the family, talk to them about it, obtain the permission forms, and make the technical arrangements with the organ procurement people or transplant teams. I think that many physicians just didn't feel that they wanted to get involved.

The real virtue of this law is that it takes the burden off of the individual physician and places it on the institution. The institution needs to have a policy that says what steps must be taken when a donor is identified.

In a city like Chicago, and throughout the State of Illinois, it's very well organized. All the institution needs to do is pick up the telephone and call the Regional Organ Bank of Illinois.



The Illinois Transplant Society is a voluntary organization of all transplant centers located in the state, including the units at Springfield and Peoria. All teams participate in this organization, and we have organ procurement coordinators readily available who are trained and highly skilled and experienced in dealing with families.

The coordinators will go to the institution, speak with the family if the physician wishes them to do so, and bring all the paperwork that's needed. They'll make sure that the nursing staff has proper in-service education, and that the administrator is up to speed in terms of all the requirements. And they will take over whenever the local hospital gives them the permission to do so.

Or, the coordinators can take a different role—that of assisting the physician, the nursing staff, the hospital administrators, the chaplain, or the social worker—whoever is identified by the hospital. The coordinator would be more than willing to help them do all of the work.

IMJ: *So if an attending physician identifies a patient who is a potential donor, all he or she has to do is make a phone call?*

Dr. Jonasson: That's right. All you need to do is call 312/RECYCLE. That's the number that will give you all of the information.

IMJ: *And what criteria should the physician use to determine whether a patient is a potential donor?*

Dr. Jonasson: Potential donors are usually younger people—especially when we're dealing with heart or liver transplantation—because youth is an advantage in terms of organ function.

The criteria for heart or liver donation are considerably more strict than for kidney donations. Many donors are suitable for kidney donation, but not for heart or liver.

The most common donors, however, are young. They've usually been in an accident or had a CVA or some other serious catastrophe, and are in a deep coma and are respirator dependent. They have fixed and dilated pupils. And they are not drug intoxicated.

If such patients have been in an intensive care unit for days, we have to think about other things. Have they become infected or septic in the intensive care unit? That would make them less desirable or less suitable. Also, they must not have a malignancy or an infectious disease because that can be transmitted to the recipient.

IMJ: *For some time, transplant surgeons have indicated that a uniform definition of death would be helpful in facilitating organ donations. Do you agree?*

Dr. Jonasson: The definition of death—of brain death—is something that I think each hospital should address, and I'm hopeful that the Illinois State Medical Society might take this on as an issue.

There is a statute that's been developed by the Commission on Uniform State Laws dealing with the determination of death, and we would like to see this enacted in all 50 states as a uniform act. It would be helpful. It would clarify things in Illinois if that were done, but I think the state medical society could play a leadership role in establishing model protocols for its members to adopt at their local hospital levels.

Some still believe that we rely on electroencephalograms or other detailed tests. This is not the case. A good clinical exam and a drug toxicology screen is often sufficient. CT scan findings and sometimes obvious injury findings are also useful, but mainly the clinical examination of the ventilator-dependent patient in deep coma is the strictest criteria, along with brain blood flow studies using nuclear medicine techniques. We have found that to be much more useful than the electroencephalogram in these patients.

IMJ: *You mentioned development of model protocols as a possible role for ISMS. What are some other things that the Society and other components of organized medicine can do to facilitate transplantation?*

Dr. Jonasson: Education of the profession. The public tends to be fairly well-educated about transplantation. The profession also needs to be educated to many aspects of organ donation and transplantation that they may be a little bit uncertain about.

For instance, many physicians are reluctant to approach a family to ask for permission for organ donation because they think it is too stressful a time. It's a very important piece of education for those physicians to realize that the families welcome this opportunity and look upon it as a very positive thing that happens in a time of real grief and trauma.

It's a very important piece of education for those physicians to realize that the families welcome this opportunity and look upon it as a very positive thing that happens in a time of real grief and trauma.

Also, generally, physicians should know how useful transplantation is and how successful it is in rehabilitating patients. If one looks at the results of cost benefit studies, I don't think that we could ever find that transplantation pays for itself. But it certainly rehabilitates patients regularly.

Three-quarters of the patients receiving successful kidney or heart transplantations are fully rehabilitated, back at work earning money and paying taxes. So it certainly is a successful type of program.

IMJ: *How about the medical schools? What is a proper role for them in this area?*

Dr. Jonasson: The medical schools, nursing schools, all health profession schools need to incorporate organ transplantation topics in the curriculum. It's part of the modern era of medicine and part of our armamentarium today. And everyone who is in school now should learn about it.

Task Force Works to Facilitate Transplants

The shortage of needed organ donors prompted Congress to pass the National Organ Transplant Act in 1984. Included in that law was a mandate for a special federal Task Force on Organ Transplantation.

It was a multi-disciplinary effort, bringing together physicians and scientists, organ procurement specialists, legal and behavioral science professionals, theologians, and experts in health care financing. The Task Force was chaired by Olga Jonasson, M.D., professor of surgery at the University of Illinois College of Medicine.

Charges to the Task Force included:

- ☐ An assessment of public and private efforts to procure human organs;
- ☐ Definition of the barriers to organ donation and the problems in coordinating procurement;
- ☐ Recommendations for the education of health professionals and the general public with respect to organ procurement;
- ☐ An analysis of issues pertaining to reimbursement for transplants; and
- ☐ A study of how transplant technology is being adopted by the health care community.

During its 15 months of study, the Task Force considered a wide range of topics related to organ procurement and transplantation. And its final report—issued in April of 1986—offered numerous specific recommendations for legislative bodies, government agencies, professional organizations and the general public.

Chief among these was the recommendation that "routine inquiry" or "required request" legislation be enacted in all states. The Task Force also called upon hospitals to adopt routine inquiry policies. The federal government was asked to require the same of its hospitals and incorporate required request provisions into Medicare regulations.

The Joint Commission on Accreditation of Hospitals was urged by the Task Force to develop a standard that requires all acute care hospitals to have: (1) an affiliation with an organ procurement agency; and (2) procedures for identifying potential organ and tissue donors and for providing next-of-kin with appropriate opportunities for donation.

Also recommended by the Task Force were state laws regarding a uniform determination of death. Other laws advocated were those requiring medical examiners and coroners to give permission for organ and tissue procurement when families consent, unless the surgical procedure would compromise medico-legal evidence.

With respect to public education regarding organ procurement, the Task Force suggested:

- ☐ A broad-scale public educational effort utilizing the news media and coordinated by a single national umbrella organization;
- ☐ Development of instructional materials for use in primary and secondary schools; and
- ☐ Special programs directed to target populations such as minority groups, families, and churches.

The Task Force suggested that professional education be improved by incorporating organ and tissue procurement and transplantation subjects into the curriculum of medical and nursing schools and into certification requirements for pertinent medical and nursing specialties. Organizations of physician specialists who frequently come into contact with organ and tissue donors were advised to establish committees and other mechanisms to facilitate communication and cooperation with physicians in transplantation specialties.

Agencies and specialists involved in organ procurement should be certified by appropriate professional organizations or government agencies, according to the Task Force. Collection of uniform data and formal agreements between organ and tissue banks also were recommended.

On the topic of organ sharing, the Task Force recommended a single national system to coordinate organ allocation and distribution. The selection of patients for waiting lists and allocation of organs should be based on medical criteria that are publicly stated and fairly applied, according to the Task Force. The commercialization of organ transplantation was soundly rejected.

Examining the issue of funding for transplants, the Task Force recommended that existing public and private financing mechanisms be extended to all transplant procedures recognized as medically effective. Under federal grant, outpatient immunosuppressive drugs should be supplied to those unable to afford them. However, the Task Force recommended that reimbursement for transplant procedures be made only to designated transplant facilities that meet explicit criteria of experience, logistic medical support, volume, and patient survival.

With respect to the number of transplant facilities, the Task Force expressed some concern over what it called a diffusion of organ transplant technology. It recommended that transplant centers be designated by an explicit, formal process using well-defined criteria. The Task Force also urged that laboratories and clinics relating to transplantation be fostered, encouraged, and increasingly funded. ◀



was a program in the black community in order to determine the factors that so frequently resulted in the families not giving permission.

A lot of superstition, fears, and a lack of trust in the physician enter into it. We also believe that we'll find that there's poor communication between the transplant centers and the black community, and that we need more direct public exposure and education of black families.

We're approaching this very seriously now with an attempt to have direct interviews with families. We are determining the needs in terms of education by communicating and increasing public relations through the churches and women's groups, the black media, and so forth, to get better exposure for transplantation.

IMJ: *We've discussed the serious shortage of available organs. But given the scarcity of organs, how do you feel about cases like that of the Chicago infant who received four liver transplants? Should a line have been drawn after one of the earlier procedures?*

Dr. Jonasson: Well, obviously that was a very difficult decision. One point of view that I've heard argued is that, since there is such a scarcity of donors, every waiting recipient gets only one opportunity. The next person deserves the next chance.

I'm sure the multiple transplant case was characterized by the physician's commitment to the family to do everything possible to save the child's life.

When does reality hit that situation? I think the decision is made when it's clear that, no matter what you do, you won't succeed. I believe that those physicians felt that things just weren't going right the first couple of times, and this time it was right and they would try and do it. And it worked.

But the other side of the coin is that there were three other patients who didn't have that chance. I think that's an extremely difficult decision to ask a doctor and a family to make.

IMJ: *Another ethical question: Should the patient's receipt of a transplant be dependent upon his or her ability to pay?*

Dr. Jonasson: Kidney transplantation is not a problem. In 1972, the Social Security Act was amended to include coverage for end stage renal disease. Since that time, over 90 percent of the American population has been covered for dialysis and transplantation of a kidney through Medicare.

It's a very expensive program for Medicare. It's going to reach $3.1 billion in 1991. Because of that fact, the government has been reluctant to engage in discussion of heart and liver transplantation because they see more huge costs coming.

However, I don't think that is a fair comparison, since over 90 percent of the costs of the end stage renal disease program aren't transplant costs, but dialysis costs. And we must realize that—even if we obtained every single one of the 25,000 potential donor organs—we still would probably be able to use only about 25 percent of donated hearts.

So we have a limitation on the number of cases that can be done, and the cost will not continue to rise as it has with kidney dialysis.

But even without those financial arguments, you must argue on other grounds. We ask everyone in this country to donate organs and to donate the organs of their loved

One point of view that I've heard argued is that, since there is such a scarcity of donors, every waiting recipient gets only one opportunity. The next person deserves the next chance.

IMJ: *Let's go back to the topic of public education for a moment. You said that overall, the public tends to be fairly well-educated on the topic. But aren't there some segments of the population that need to be targeted with educational efforts?*

Dr. Jonasson: Yes. We have serious discrepancies in the frequency of organ donation in the inner city, especially in the black population.

Last year, the Regional Organ Bank of Illinois Inc., was awarded a federal grant to develop our regional organ procurement activities. One of the main thrusts of the proposal

Transplant Facts*

Nationwide Statistics

- ☐ 200 children currently waiting for livers, of which 100 will die from lack of available organs.
- ☐ 200,000 people waiting for some type of organ or tissue transplant.
- ☐ 24,000 people declared brain dead each year, of which 14-17 percent will become donors.

Illinois Organ Donations
Organs procured by the Illinois Transplant Society in 1986:

- ☐ Total donors: 200
- ☐ Bone donors: 66
- ☐ Skin donors: 31
- ☐ Organs obtained:
  kidneys: 268
  hearts: 47
  livers: 57
  pancreata: 27

*Source: Illinois Transplant Society

ones, never telling them that the only people who can receive these organs are the ones who can pay for them.

It's unfair to ask everyone to donate an organ but restrict those who can receive a transplant to those who can pay.

So I believe, in the interest of equity, there must be a federal program to pay for heart and liver transplantation for eligible patients. We cannot disallow the opportunity for patients in need simply on the basis that they don't have the money to pay for it.

IMJ: *As with any other commodity, the shortage of donor organs can encourage their buying and selling for profit. Is commercialization of organ donation a problem?*

Dr. Jonasson: Commercialization could be a serious problem in transplantation.

Buying or selling organs or tissues is unfair. The sale of body parts by the poor is a form of enslavement and purchase by the highest bidder is unfair.

It is looked upon throughout this country as being an extremely serious infringement on ethical standards to buy and sell organs and tissues.

1986 Organ Transplants

Organ/ Tissue	Number Transplanted**	Success Rate	Number Waiting**	Cost
Kidney	10,566	95%	10,000	$ 25,000- 35,000
Heart	1,427	80%	320	57,000-110,000
Liver	898	65-70%	300	135,000-238,000
Pancreas	130	70%	50	30,000- 40,000
Heart/Lung	50	75%	50	130,000-200,000
Cornea	28,000	85-90%	4,000	$ 5,800

***1986 Statistics from United Network for Organ Sharing*

Obviously, there are costs associated with organ procurement. The operating room, the intensive care costs, the transportation costs, the personnel costs. So obtaining an organ from a donor is an expensive proposition. These are costs that rightly must be borne by the recipient. Buying and selling is, however, something that we think would destroy the voluntary altruistic system of organ donation.

IMJ: *Earlier, you made it sound like organ procurement was very well organized in Illinois. But what about the national scene? Is there fragmentation in the effort to procure donor organs?*

Dr. Jonasson: There has been a hodgepodge of systems nationwide. Many transplant centers have their own organ procurement program. Others use independent organ procurement agencies.

Several large cities have competing organ procurement agencies, each vying for donors from the same hospital. This detracts from positive thoughts about organ transplantation, and I think it has held back organ procurement activities in those cities very substantially.

IMJ: *What makes Illinois' system so much better?*

Dr. Jonasson: In Illinois, I think we've done exactly the right thing. We have taken all organ procurement for all transplant programs and centralized it in a single agency. *(Editor's Note: See story on page 307.)*

That agency carries the banner for transplantation in Illinois. Its coordinators then represent the patients and the patients' needs rather than one particular university.

Not only is this much more efficient and cost-saving, but it also gives a much better image and promotes public educational activities. There aren't people wasting their time competing over who gets which donor today, and certainly I think there's incentive to hold costs down by doing this.

IMJ: *How about the facilities in which transplants are done? Do we have enough of them in this state?*

Dr. Jonasson: Transplantation is a young field, as I mentioned, and it's growing rapidly.

One of the ways in which it has grown is through research. Without research in transplantation, we would still be back at the beginning.

It takes constant research to continue to improve the immunosuppressive drugs, the patient selection, the tissue-typing matching criteria, and other factors related to the very complex immunology of transplantation.

That's a long answer to say that transplant centers should be located in academic centers. Because in medical schools or in university environments, the research is undertaken that will advance the field.

It's unfair to ask everyone to donate an organ but restrict those who can receive a transplant to those who can pay.

Yes, we have enough transplant centers in Illinois. They are located in the medical schools. And no, we don't have too many, because so much research remains to be done.

That, I think, is the strongest justification for having several heart transplant and several liver transplant centers in a city like Chicago, where there are academic institutions with the resources and drive to do the research that's needed.

It's also one of the reasons that I do not think that organ transplantation should be done in community hospitals. The opportunity there to do research is lost. And since there is a limitation on the number of donors that are available, an organ donor sent to a nonresearch hospital means that the research facility does one transplant less and, consequently, does less research. So I think the public is better served by having the transplant programs being performed in centers where research is carried on. ◀

Agencies Coordinating Transplants in Illinois

In Illinois, most procurement of donor organs and transplantation is coordinated by a single agency, the Illinois Transplant Society. The Society helps match potential donors with those patients needing transplants.

The Society maintains a 24-hour telephone line (312/RECYCLE) to help arrange transplants when donor organs become available. Records of patients needing transplants are computerized to facilitate the matching process. A centralized tissue matching lab at the University of Illinois also is maintained by the Society to ensure the best match between donor and recipient.

The Society was formed in 1975 as the Illinois Transplant Surgeons Association, with representation from the six university-affiliated transplant centers in Illinois. Its name was changed to the Illinois Transplant Society in 1981.

The Society has recently formed the Regional Organ Bank of Illinois, Inc. (ROBI), through a grant from the federal government. Included in ROBI's current activities are organization of all organ procurement activities in Illinois under a single, central unit, development of a master data set for clinical studies, and a program of public and professional education regarding organ donation in the inner city.

Another agency involved in transplantation in Illinois is the Experimental Organ Transplantation Program, which operates within the Illinois Department of Public Health. The program was set up to provide financial assistance to patients whose insurance does not cover the costs associated with transplants still deemed "experimental" by the insurers.

Procedures that may come under this program include heart, heart/lung, single lung, adult liver, and pancreas transplants. Up to $200,000 per procedure is available upon the recommendation of a board of 13 physicians appointed to oversee the program. To date, funds appropriated by the Illinois General Assembly have been sufficient to permit payment of all procedures that have met the criteria necessary to qualify.

The program began July 1, 1985 under a bill sponsored by Senator Judy Baar Topinka (R-Riverside). Information regarding the program may be obtained from its coordinator, Jeanne Cronister, at the Illinois Department of Public Health, 217/782-3303. ◀

Public Attitudes on Organ Donation

The public's attitude toward organ donation is a key determinant of whether the supply of donor organs will ever become adequate. A study reported by the American Medical Association in 1985 and a public survey conducted for the American Council of Transplantation that same year indicate room for improvement in public understanding and acceptance of organ donation.

A telephone survey of 2,056 respondents reported in the June 7, 1985 issue of *JAMA: The Journal of the American Medical Association* revealed that:

- ☐ Nearly 94 percent of the population had heard about organ transplantation, but only 19 percent carried donor cards.
- ☐ Only about 19 percent were truly unwilling to donate their organs, while 53 percent were uncertain.
- ☐ People are somewhat more likely to donate the organs of a relative who had just died (53 percent) than they are to donate their own organs (50 percent).
- ☐ Most respondents (58 percent) indicated that next of kin should not be able to override a person's desire to donate organs as evidenced by a signed donor card.
- ☐ Less than half (44 percent) indicated that the next of kin should be allowed to donate the organs of relatives who had recently died without signing a donor card.
- ☐ Few people (seven percent) supported the concept of presumed consent for organ donation. An overwhelming majority (86 percent) indicated that physicians should not have the power to remove organs from people who have not signed cards without consulting the next of kin.

Sizable differences exist in responses among various economic and ethnic groups. Generally, willingness to donate organs increased with education and income. With respect to racial considerations, whites were much more willing to donate than non-whites.

Less than seven percent of those responding to the survey reported that they received their information about organ donation from physicians or nurses. Newspapers and magazines (37 percent) were the primary source of information, with television running a close second (35 percent).

Some differences also existed regarding which organs a person is willing to donate. Most popular was kidney donation (50 percent), while skin and whole-body donation were least probable (40 percent). Other responses were: liver-47 percent; corneas-46 percent; heart-46 percent; pancreas-44 percent; and lungs-44 percent.

The survey, conducted for the American Council of Transplantation, revealed that 62 percent of respondents would not mind if their organs were donated upon their death. However, 53 percent were uncomfortable about agreeing to donate an organ while they were still alive.

In other data, 73 percent of the respondents said they would be very likely to give permission to have the organs of a family member donated after that person's death. Some 44 percent said they would be very likely to donate their child's organs if the child died suddenly.

Criteria for Organ Donors

People of all ages may be considered potential organ donors. Children under age 18 may become donors if their parents or legal guardians consent. A parent's or guardian's signature on the Uniform Donor Card as a witness is deemed sufficient consent for transplant purposes.

Decisions on the medical suitability of a person's organs for transplant are made at the time of death. However, ideal organ donors customarily are previously healthy people who have suffered an irreversible injury that results in brain death.

Donors usually are found among people who have suffered acute head or neurological trauma, subarachnoid hemorrhages, strokes, primary brain tumors, hepatic coma, and in some cases drug overdoses and smoke inhalation. Suicide and homicide cases are usually acceptable once permission is obtained from the local medical examiner or coroner.

Contraindications

There are few absolute conditions which preclude a person from serving as an organ donor. A history of cancer (except primary brain tumor) or certain chronic diseases may bar acceptance of other than

Organ Donation Made Easy

Considerable efforts have been made by the health care community, state agencies, and other entities to facilitate organ donation.

Chief among these is development of the "Uniform Donor Card" which is available from multiple sources. By law, all such cards are identical in format. In Illinois, cards may be obtained from the Illinois Society for the Prevention of Blindness (312/922-8710), Illinois Transplant Society (312/732-9253), National Kidney Foundation of Illinois (312/663-3103), and the Lions of Illinois Eye Donor Registry (312/771-3937).

In addition, a Uniform Donor Card is printed on the back of all Illinois drivers' licenses. Although laminated in plastic, drivers' licenses have been designed to permit writing on the back with a ballpoint pen. The Illinois Secretary of State's Office also has distributed with license renewal forms a brochure encouraging residents to use the card.

Persons who wish to become potential organ donors need only sign and carry with them a copy of the Uniform Donor Card. The card allows the potential donor to designate to which organs the consent applies. It also can be used to consent to whole-body donation for medical study.

To be valid, the signature of the potential donor must be witnessed. Space is provided on the card for the signatures of two such witnesses.

If a potential donor changes his or her mind, the card can be rendered invalid simply by destroying it. For drivers' licenses, the word "VOID" should be written across the card to invalidate it. ◀

eye donations. Generally:

- ☐ Visceral organ donors should be under 65 years of age, require a respirator, and offer a reasonable expectation of cardiovascular stability.
- ☐ Eye donors may be of any age, but should be free of such conditions as AIDS, Creutzfeldt-Jakob disease, encephalitis, hepatitis, and rabies.
- ☐ Skin donors should be 12-60 years old, and be free of skin cancer, leukemia, skin infections, extensive dermatitis, and a history of hepatitis.
- ☐ Bone donors should be 15-55 years old, and exhibit an absence of hepatitis, AIDS, syphilis, tuberculosis, brain tumors, systemic infections, autoimmune process, substance abuse, and bone pathology.

Determining Brain Death

Basic to transplant activity is the determination of brain death. It is the physician's examination and evaluation of the potential donor's own circumstances upon which a determination of brain death will rest. However, some general guidelines can assist the physician in making a decision.

Generally, for the patient who—after appropriate diagnosis and therapeutic procedures—remains apneic and unresponsive with circulation maintained, the following criteria can be used to determine brain death:

- ☐ No spontaneous movement and no response to painful stimuli.
- ☐ No spontaneous respiration.
- ☐ Absence of brain stem reflexes:
  Dilated and fixed pupils;
  Absence of corneal reflexes;
  Absence of ciliospinal reflexes;
  Absent doll's head phenomenon (oculocephalic reflex);
  Absent gag reflex;
  Absent vestibular response to caloric stimulation; and
  Absent tonic reflex.
- ☐ A status in which all of the findings remain unchanged for at least six hours. If visible evidence of massive irreparable injury to the brain exists, the six-hour waiting period may be reduced.
- ☐ Pathologic process responsible for the above must be deemed irreversible.

The electroencephalogram—when available and deemed appropriate—as well as brain scans and cerebral arteriography are considered aids in the determination of total cerebral death. Their use is optional. EEG is not mandatory.

Arranging an Organ Donor

Once a physician has identified a possible organ donor, arrangements for the donation are easily made. In most cases, a single telephone call is all that is needed to initiate the process.

Most Illinois organ procurement is coordinated through the Illinois Transplant Society, which can be reached at 312/732-9253 (312/RECYCLE). ◀

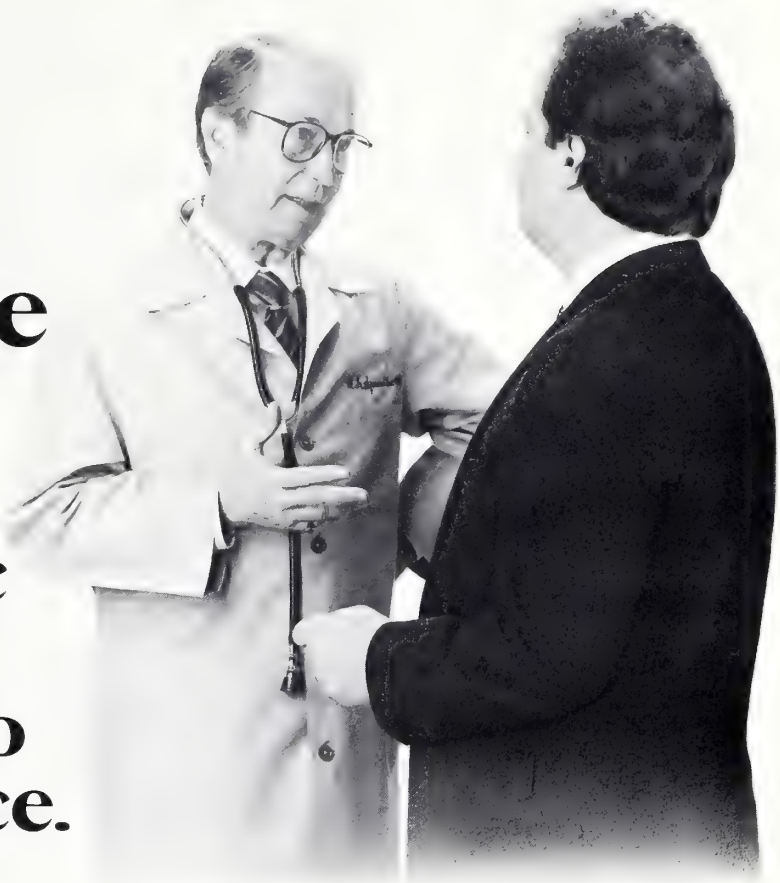
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Job Hunting for the Medical Assistant

By Robin Bluestein, CMA-C

As a recent participant in the medical assisting job market, I wanted to share my experience with others in my situation, as well as the physicians who will be hiring these individuals. Success is rooted in experience, solid preparation, job interviewing skills and, once hired, making the most of your position. In addition to organizing your job search, "being in the right place at the right time," is a great advantage. As the applicant has little control over the latter, it is wise to focus on the former: experience, preparation/planning, job interviewing and making the most of your job after being hired. (Editor's Note: This article originally appeared in the May 1986 issue of IMJ. *It is being reprinted here due to the unusually large volume of requests received for this information. Part two of this series will again appear in the July issue.)*

Certainly, if this is your first experience in searching for a job, you will have no prior knowledge as to what you must do to prepare. If you are a recent graduate from a medical assisting program, you know the kinds of responsibilities you can expect. You will have a medical assisting education and practical experience through an externship in physicians' offices. You will have undoubtedly chosen whether you would like a job administratively and/or clinically. You will know that a position asking for an individual to do laboratory work, EKGs and vital signs will not be for you if you have decided you would like to do front office work.

Job experience will play a part in the type of position for which you will apply. Some jobs require several years of experience while others require none. Medical assistant certification is becoming more important in the job market as more and more positions require it. Physicians can expect a certified medical assistant to be proficient in the skills they will perform in their job setting. Although certification is not mandatory, it demonstrates an interest in excellence.

In order to retain their certification credentials (beginning in 1988), medical assistants must either take the examination every five years or attain a set number of continuing education units (by attending seminars, courses and reading appropriate material) in a five year period. An individual hiring a "certified medical assistant" will be offering more, both in responsibilities and financially, than one hiring a "medical assistant." If you are not yet certified, make certification a short-term goal!

The next step is preparation and planning. Begin with your resume. A resume is not a one-time endeavor. It should be a document that can be continuously updated as you reach goals in your career path. If you have had no experience in writing a resume, consult with a friend who has and/or research books on the subject. Many books will give you outlines for resume writing.

After typing your resume, begin to check the advertisements (I find the Sunday paper offers the most and the best positions). Some ads state very little about a position and some state what the entire position entails. An ad might state: MEDICAL ASSISTANT call JOAN 976-1212. Another ad might state: CERTIFIED MEDICAL ASSISTANT, Lab work, EKGs, patient contact, light typing, salary commensurate with experience and ability, many benefits, send resume to. . . .

There are many things to consider when answering an ad. Will you answer every position offered for a medical assistant or stick with those with responsibilities of interest to you? What are the stated responsibilities? Are they tasks you can accomplish or can learn? With whom will you be working—a specialist, general practitioner, one physician or many physicians? Will it be a "one girl" office or does the practice employ many individuals? Where is the practice located—near your home, near public transportation or must you drive? Does the position you are applying for have room for advancement? Many of these questions will be answered in the ad and many will be answered in a phone conversation and/or interview. You must consider these questions and many others you will come up with yourself.

The advertisement will either state an individual to call for more information or ask that you send a resume to a certain address. In the former instance, be prepared to ask any questions during the phone conversation. If the individual has an interest in you, expect to be called in for an interview. If a resume is necessary, be sure to include a cover letter. As with the resume, research books will help you with typing a cover letter.

Look to the July issue for part two of this series, which will focus on job interviewing and making the most of your job after being hired.

Information regarding the Illinois Society and/or medical assisting can be obtained from Cheryl Hutchison, CMA, president, Illinois Society, 53 Lockhaven, Granite City, 62040. ◀



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Auxiliary . . . A Network Opportunity

By Lynn Kassel (Wayne), President

During the past year, as ISMSA President-Elect, I became very conscious of how unaware auxilians are of the opportunities that exist within the network of Auxiliary. For this reason, I have chosen as my theme "Auxiliary . . . A Network Opportunity." It is with this message that I will travel to the counties in Illinois over the next year.

To comprehend the opportunities of which I speak, it is necessary to review the history of Illinois' Auxiliary. Having been involved in a small way when the ISMS Auxiliary wrote its 55-year history in 1983, I turned to those pages as a source of the past before I moved to accept command of its future.

On a return trip from the AMA convention in 1927 Dr. and Mrs. Henry Mundt, along with Dr. Harold Camp, determined that Illinois should have an auxiliary just as the AMA did. The AMA Auxiliary was started in 1922, and by 1927 twenty-two states had formed auxiliaries and seven more were in the process. Women within these states were assisting the medical profession in many educational, legislative, and other programs. In 1927 the ISMS House of Delegates passed a resolution stating: "Be it resolved that (1) the House of Delegates of the Illinois State Medical Society endorse the organization of the Women's Auxiliary within the State of Illinois; (2) that all delegates will impress on their respective societies the importance of cooperating with the movement; (3) that the individual members of the Society be urged to tell their wives of the value of such a cooperative society to the medical profession and induce them to assist in the movement; and (4) that the women be urged to start their organization at this meeting."

And here we are 60 years later, doing the same work educationally and legislatively, with only a few changes in the process—the elimination of "Woman's" in the name and the change to Illinois State Medical Society Auxiliary in 1975.

The network was firmly established in 1927 and grew rapidly as each year brought new states into the federation. Individual units were formed under each state, until by the mid-50s auxiliaries extended into most areas of the country. Working with health education, immunization, the efforts of the war years, physicians' spouses worked together for a common goal . . . "Our Husbands, Our Homes, Our Community, Our Country," as the original slogan went.

The 60s brought a healthy look at the past and a new determination for the future. The decade took its toll on volunteer organizations, however. Membership remained static instead of growing. New physicians began to look sharply at organized medicine, and by the 70s were turning their backs on it. Women began their own search for identity, demanding a separate life from their spouse or family. Raising families lost popularity; identifying careers spelled success. Women were marching for themselves and were self-conscious, even embarrassed, to be linked to medicine, unless it was their own choice of career. And for many it was.

By the early 80s, 30% of medical students were women, and by the year 2000, the number will be 50%. Their spouses probably will not be physicians, and none of them will be likely to make "Our Wives, Our Homes . . ." their slogan. But have the needs really changed? Who will support medicine in the community? Who will battle the detractors?

The physician spouse will. Whether male or female, the objectives remain the same. Someone needs to support the person behind the image of the doctor. Our knowledge of medical matters, although light years beyond what the 20s defined as "breakthrough," still needs to be balanced with judgment and compassion. To achieve these traits you need a whole human

being; one who feels secure. Those of us who have shared the experiences of a physician agonizing over decisions about another's life know that there is clearly a need for our network of auxiliary. The opportunities are there whether your choice is the legislative arena—which can train you to lobby for a campaign or a candidate, or the educational field—where you can develop programs affecting the adolescent, the elderly, the abused child. Raising funds for our own medical family through benevolence contributions, or for our medical schools and students through AMA-ERF have been primary endeavors which have reaped millions of dollars on their behalf.

In the process you can enhance your own career, documenting your education and involvement through the AMA Auxiliary's Professional Skills Development program. You can teach your peers while you develop your leadership skills. You can enhance your marriage by working for a common goal of quality medicine in an era where cost containment is fast becoming the determining factor in patient treatment, and the cost of professional liability insurance proves to be the early demise for many physician careers.

The network was established long ago . . . the opportunities have developed in answer to the critical look of the 60s generation. What we need is the manpower to fill the jobs. The numbers are there. ISMS and AMA are growing in membership. Young physicians are again looking to organized medicine to impact the future. Will the spouses be there to support the structure?

The need is growing, not diminishing. By now we should all have found our identities and be ready to join together and strengthen the network. Let us remind ISMS of their initial resolve to "impress on their respective societies the importance of cooperating with the movement." Let us establish auxiliaries in the 87 communities with medical societies, but only 29 auxiliaries, some of which are not functional. Let us establish alternative methods of organization to assist the auxiliaries that struggle due to geographics. It is time to grow again through Auxiliary . . . A Network Opportunity. ◀

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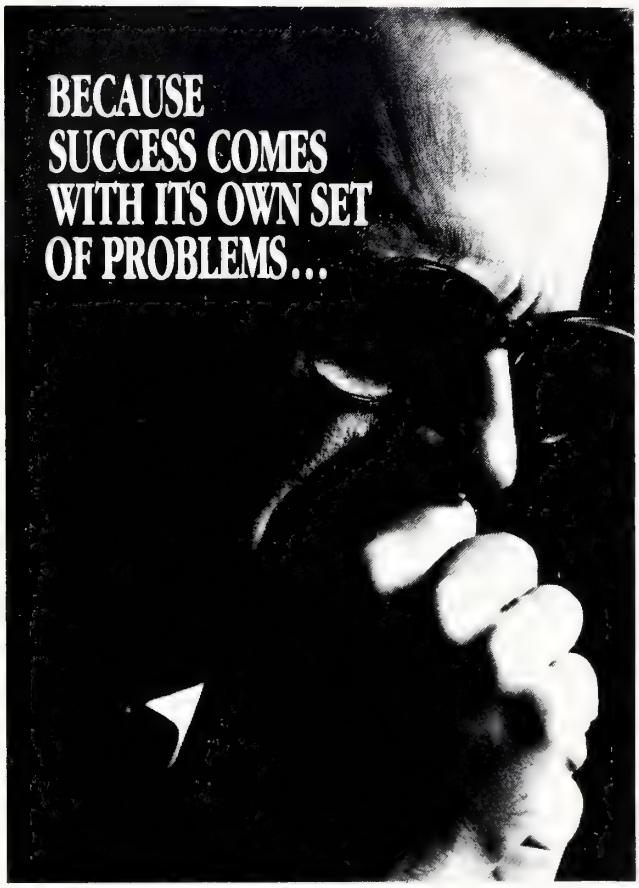
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OBITUARIES

***Duve, Susan,** Lake Forest, died March 6, 1987 at the age of 46. Dr. Duve was a 1966 graduate of the University of Iowa College of Medicine, Iowa City.

***Fleischl, Franz K.,** Springfield, died March 11, 1987 at the age of 74. Dr. Fleischl was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

****Hamm, Lee N.,** Lincoln, died March 17, 1987 at the age of 81. Dr. Hamm was a 1929 graduate of the Washington University School of Medicine, St. Louis, Missouri.

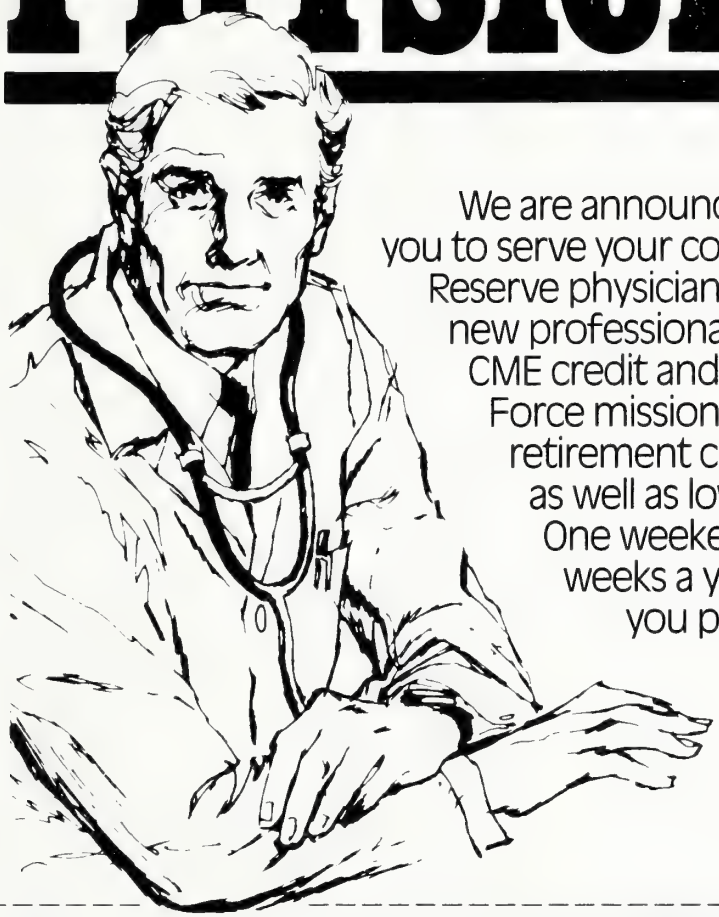
***Larson, William,** Annawan, died February 20, 1987 at the age of 68. Dr. Larson was a 1945 graduate of the University of Health Sciences/Chicago Medical School.

***Morgan, C. Duane,** Peoria, died March 7, 1987 at the age of 36. Dr. Morgan was a 1975 graduate of the Indiana University School of Medicine, Indianapolis.

***Muenster, Joseph J., Jr.,** Chicago, died March 1, 1987 at the age of 63. Dr. Muenster was a 1947 graduate of the St. Louis University School of Medicine, St. Louis, Missouri. ◀

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(continued from page 275)

Diagnosis: Crohn's disease with fibrofatty proliferation of mesenteric fat

Computed tomography shows displaced small bowel on the barium examination (Figure 1) and a large collection of fat, which was palpable on physical examination. (Figure 2)

Fibrofatty lesions, which are found in some patients with Crohn's disease, may be detected by physical examination and barium studies of the intestine. Although not responsible for symptoms, they are important because their appearance on physical examination and small bowel studies may be identical to such complications as abscess or phlegmon. In a patient who is symptomatic and has fever secondary only to exacerbation of disease, the presence of these masses may lead to the mistaken diagnosis of a complication. The patient presenting here had symptoms related to an exacerbation of Crohn's.

Complications of Crohn's Disease

Crohn's disease is a chronic disorder characterized by granulomatous inflammation of the gastrointestinal mucosa, bowel wall and surrounding mesentery. The disease most commonly presents with such typical signs and symptoms as abdominal pain, fever, anorexia and weight loss in a young adult. Diagnosis is made when classic mucosal abnormalities including aphthous lesions, pseudopolyps, ulcerations and skip areas are found.

Diagnostic problems occur more frequently when a patient develops a complication of Crohn's disease. For example, the patient presented here could have had reactivation of his disease or a complication. In this case the presence of an abdominal mass is highly suspicious for an abscess or phlegmon. In this type of patient, barium studies show mucosal abnormalities along with separation of bowel loops and mass effect.[1] The extraluminal extent and nature of disease can only be inferred. Unfortunately many different complications of Crohn's disease, as well as abdominal processes unrelated to Crohn's disease, can give these same findings.[6] (see Table 1)

Prior to the availability of computed tomography, exploratory laparotomy was sometimes required to differentiate these very different clinical entities. Computed tomography can now provide more accurate diagnosis because the abdominal cavity can be directly demonstrated.

Common CT Findings in Crohn's Disease

Bowel Wall Thickening

As seen in Table 2, the most consistent CT finding in studies performed on patients suspected of having complications of Crohn's disease is bowel wall thickening.[1-3] In the early phases of the disease, this thickening represents edema, lymphangiectasia, and monocellular

Table 1
Differential Diagnosis of Separation of Bowel Loops[6]

Processes that thicken or infiltrate the bowel wall or mesentery
Crohn's Disease
Bowel wall thickening alone
Fibrofatty proliferation of mesenteric fat
Abscess
Phlegmon
Lymph node enlargement
Whipple's Disease
Amyloidosis
Intestinal hemorrhage
Mesenteric vascular occlusion
Radiation-induced enteritis
Neurofibromatosis of the small bowel
Mesenteric lipomatosis
Neoplasms
Lymphoma
Primary carcinoma of the small bowel
Primary tumors of the peritoneum/ mesentery (mesothelioma)
Metastases (peritoneal carcinomatosis)
Liposarcoma
Carcinoid tumor
Intraperitoneal Abscess
Ascites
Hepatic cirrhosis
Peritonitis
Congestive heart failure
Constrictive pericarditis
Peritoneal carcinomatosis
Primary or metastatic disease of the lymphatic system
Retroperitoneal hernia
Paraduodenal
Paracecal
Intersigmoidal
Retractile Mesenteritis

Table 2
CT Findings in Complicated Crohn's Disease

	Goldberg, *et al.*[1]	Gore, *et al.*[2]	Gore, *et al.*[3]	Total
Bowel Wall Thickening	(23/28) 82%	(17/17) 100%	(15/15) 100%	(55/60) 92%
Fibrofatty Proliferation	(11/28) 39%	(7/17) 41%	(7/15) 47%	(25/60) 42%
Abscess	(7/28) 25%	(10/17) 59%	(2/15) 13%	(19/60) 32%
Lymph Node Enlargement	(5/28) 18%	(3/17) 18%	(3/15) 20%	(11/60) 18%
Phlegmon	—	(1/17) 6%	—	—
Fistulae	(9/28) 32%	(3/17) 18%	(3/15) 20%	(15/60) 25%

infiltrate.[1] In more advanced stages, fibrosis and transmural cellular infiltrate predominate.[2] (Figure 2)

This thickened small bowel appears on CT as concentric rings of different density. This sign has the appearance of a halo with an inner low attenuation ring composed of edematous irregular mucosa with adherent mucous, surrounded by an outer high attenuation ring composed of thickened fibrosed submucosa, muscularis and serosa.[4]

Fibrofatty Proliferation of Mesenteric Fat

Some degree of fibrofatty proliferation is the second most common CT finding in patients with suspected complications of Crohn's, ranging from 39% to 47% in incidence.[1-3] Known to pathologists as "creeping mesenteric fat," this is thickened, stiff, abnormal fat which is covered with gray-white exudate. This exudate tends to "creep" over the serosa and may hypertrophy and nearly encompass the bowel in areas of maximum involvement. In some patients this results in a fatty mass, as seen in the case presented here. (Figure 1)

In such cases, computed tomography demonstrates a dense mass of separating loops of diseased, thickened bowel, most commonly in the right lower quadrant. The abnormal tissue is identified as fat when the attenuation coefficient (−70 to −90 Hounsfield units) approaches that of normal mesenteric fat (−100 to −160 Hounsfield units). This greater attenuation is due to the accompanying inflammatory cells and fluid which have a more positive or higher coefficient than normal fat. The density of these fibrofatty masses on CT is much less than the density which would be found in an abscess or phlegmon.

The two most common entities which may resemble creeping fat on CT are liposarcoma and mesenteric lipomatosis. Liposarcomas are rare and usually have more density or inhomogeneous density. Mesenteric lipomatosis tends to be more diffuse, rather than localized to one region. Bowel wall thickening or the other changes of Crohn's do not appear in liposarcoma or mesenteric lipomatosis.[4]

CT Findings of Other Crohn's Complications

Abscesses appear as masses of near fluid density that may contain air. They can also contain contrast material if there is a fistula or sinus tract. Abscesses are most commonly seen in the mesentery, psoas muscle or perirectal region.[2] Enlarged lymph nodes are seen as nodular soft tissue densities in the mesentery. Phlegmon is usually identified as an ill-defined mass of soft tissue density.[2] It may not be possible to differentiate phlegmon from an abscess on a CT scan.

Conclusion

Fibrofatty proliferation of mesenteric fat is a very common sequela of Crohn's disease, one which requires no treatment. Its importance lies in its ability to cause a mass effect on physical examination and barium studies, thereby mimicking serious complications of Crohn's including abscess, lymphadenopathy and phlegmon. In patients without a known diagnosis of Crohn's disease, this mass effect may simulate many additional abdominal processes, including lymphoma and carcinoma. This entity has a very characteristic appearance on computed tomography, so that CT can be used to avoid further evaluation or invasive procedures in these patients. ◀

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

June

Critical Care Medicine

Critical Care Medicine
For: Critical care and primary care physicians, surgeons, and anesthesiologists. Lecture, June 8-13, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $680. **Reg. Limit:** None. **Credit:** Category 1: 56 hours; Other: PREP: 56 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Family Medicine

Oncogenes in Understanding Cancer
For: Interested physicians. Lecture, June 23, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, ext. 3484.

Medicine

New Directions in Thrombolytic Therapy
For: Interested physicians. Lecture, June 30, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Orthopedics

Specialty Review in Orthopedic Surgery
For: Orthopedic surgeons. Lecture, June 21-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $765. **Reg. Limit:** None. **Credit:** Category 1: 68 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Pediatrics

Specialty Review in Pediatric Cardiology
For: Pediatric cardiologists. Lecture, June 2-5, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $575. **Reg. Limit:** 90. **Credit:** Category 1: 34 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Respiratory Diseases

For: Interested physicians. Symposium, June 18, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $20. **Reg. Limit:** None. **Credit:** Category 1: 7.75 hours; AAFP Prescribed: 7.75 hours; and ADA: 7.75 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

Surgery

Peripheral Nerve Injury and Repair: The Practical Aspects
For: Surgeons. Lecture, June 11-13, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $1,100. **Reg. Limit:** 60. **Credit:** Category 1: 26 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons and internists. Lecture, June 20, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $160. **Reg. Limit:** 75. **Credit:** Category 1: 7 hours; AAFP Prescribed: 7 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Burns-Wound Healing
For: Physicians. Lecture, June 2, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, ext. 3484.

Antibiotics in General Surgery
For: Surgeons. Lecture, June 16, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, ext. 3484.

Obstetrics/Gynecology

Obstetrics and Gynecology Review Course
For: Obstetricians and gynecologists. Course, June 8-13, Chicago. **Sponsors:** Medical Schools of Illinois, c/o The University of Chicago, School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $550 **Reg. Limit:** None **Credit:** Category 1: 39 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 902-1056.

Cardiology/Psychiatry/Family Medicine

Cardiovascular Pharmacology Symposium: Pharmacologic and Clinical Interrelationships Between the Heart and the Brain.
For: Physicians and other health professionals. Symposium, June 10-12, Milwaukee, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, Cardiovascular Disease Center and Dept. of Psychiatry, Milwaukee Campus, Mt. Sinai Medical Center, and Continuing Education and Research Foundation, Inc., Milwaukee, WI. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 17 hours; AAFP Prescribed: Credit pending; AOA Category 2-D and University of Wisconsin CEUs: 17 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Otolaryngology

Myocutaneous Flap Reconstruction of the Head and Neck
For: Otolaryngologists. Workshop, June 12-13, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $600. **Reg. Limit:** 60. **Credit:** Category 1: 16 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Endoscopic Sinus Surgery
For: Otolaryngologists. Workshop, June 20-21, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $700. **Reg. Limit:** 60. **Credit:** Category 1: 12 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Family Practice/Internal Medicine/Oncology

Clinical Home Care in the 1980s: Economics, Implementation, and Ethical Issues
For: Physicians and other health professionals. Conference, June 25-26, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, Dept. of Medicine, School of Medicine, Regional Services/Home Care, Nutritional Sciences, Pharmacy Dept.; and Visiting Home Services. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 13 hours; AAFP Prescribed: Credit pending; AOA Category 2-D: 12½ hours; Univ. of Wisconsin CEU's: 13 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

July

Stress Management and Relaxation Skills

Teaching Stress Management and Relaxation Skills
For: Physicians and other health professionals. Workshop, July 13-17, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, LaCrosse Exercise and Health Program, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP: 35 hours; and 3.5 CEUs from UW-LaCrosse. **Contact:** Philip K. Wilson, Ed.D., University of Wisconsin-LaCrosse. **Phone:** (608) 785-8686.

Cardiac Rehabilitation

Cardiac Rehabilitation Workshop
For: All interested physicians and other health care professionals. Workshop, July 20-24, LaCrosse, WI. **Sponsors:** University of Wisconsin-LaCrosse, LaCrosse Exercise and Health Program, Mitchell Hall, LaCrosse, WI 54601 and Wisconsin Heart Institute. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; AAFP: 35 hours; and 3.5 CEUs from UW-LaCrosse. **Contact:** Philip K. Wilson, Ed.D., University of Wisconsin-LaCrosse. **Phone:** (608) 785-8686.

Otolaryngology

Endoscopic Nasal Sinus Surgery
For: Otolaryngologists. Lecture, July 27, Oakbrook, IL. **Sponsor:** Loyola University Stritch School of Medicine, 2160 S. First Avenue, Maywood, IL 60153. **Fee:** $400. **Reg. Limit:** 30. **Credit:** Category 1: 7 hours. **Contact:** Division of Continuing Medical Education. **Phone:** (312) 531-3236.

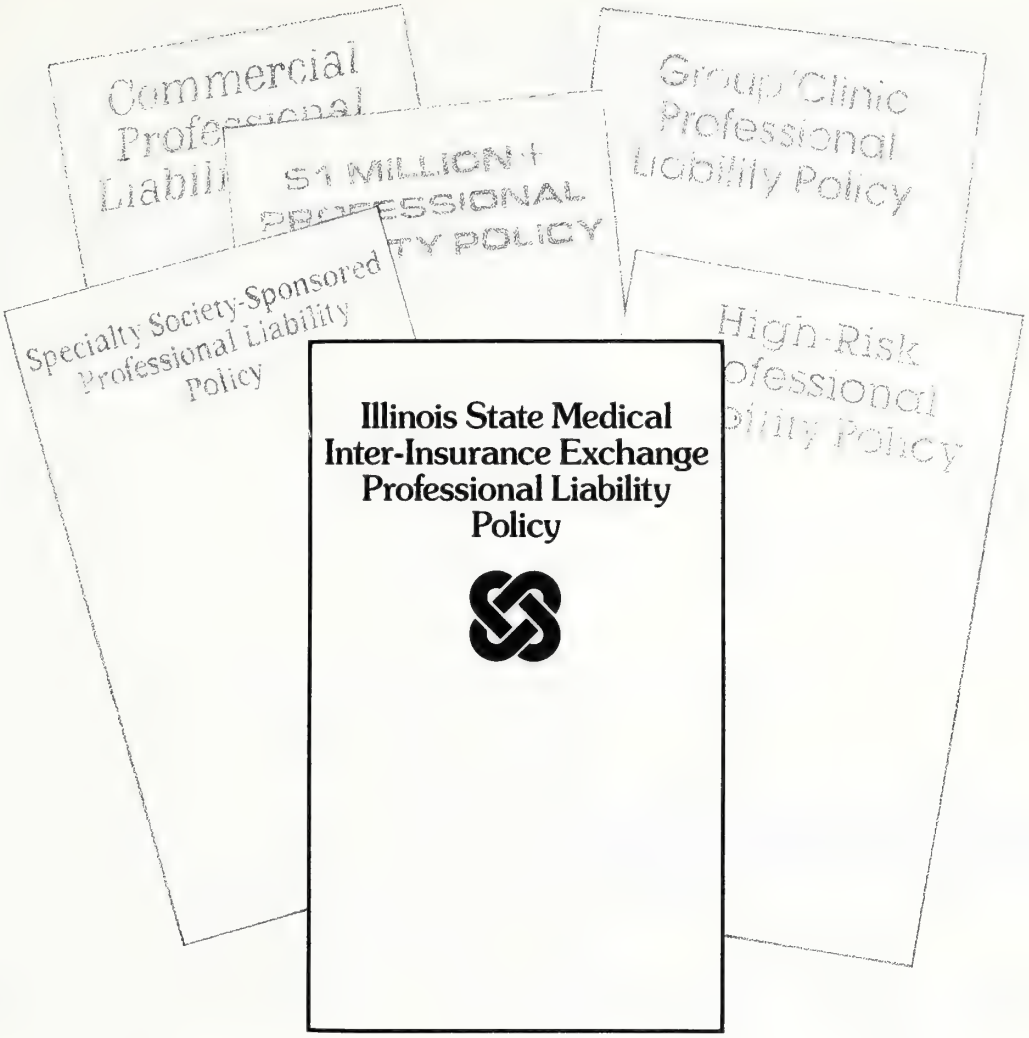
August

Orthopedic Surgery

Practical Management of Orthopedic Infections
For: Physicians. Seminar, August 7, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours. **Contact:** Loretta Giacoletto. **Photo:** (800) 325-9862.

Psychogerontology

Third Congress of the International Psychogeriatric Association
For: Interested physicians. Symposium and workshops, August 28-31, Palmer House, Chicago. **Sponsor:** International Psychogeriatric Association, 259 E. Erie, Rm. 448, Chicago IL 60611. **Fee:** $320. **Reg. Limit:** None. **Credit:** Category 1: 1 hour of credit for every hour attended. **Contact:** Jill Cohen. **Phone:** (312) 908-1248.



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Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

May 25	LaGrange Memorial Hospital	*LaGrange*
June 2	Lakeside VA Medical Center	*Chicago*
June 2	Skokie Valley Hospital	*Skokie*
To Be Announced	Hinsdale Sanitarium and Hospital	*Hinsdale*
To Be Announced	Resurrection Hospital	*Chicago*
To Be Announced	West Town Public Health Clinic	*Chicago*

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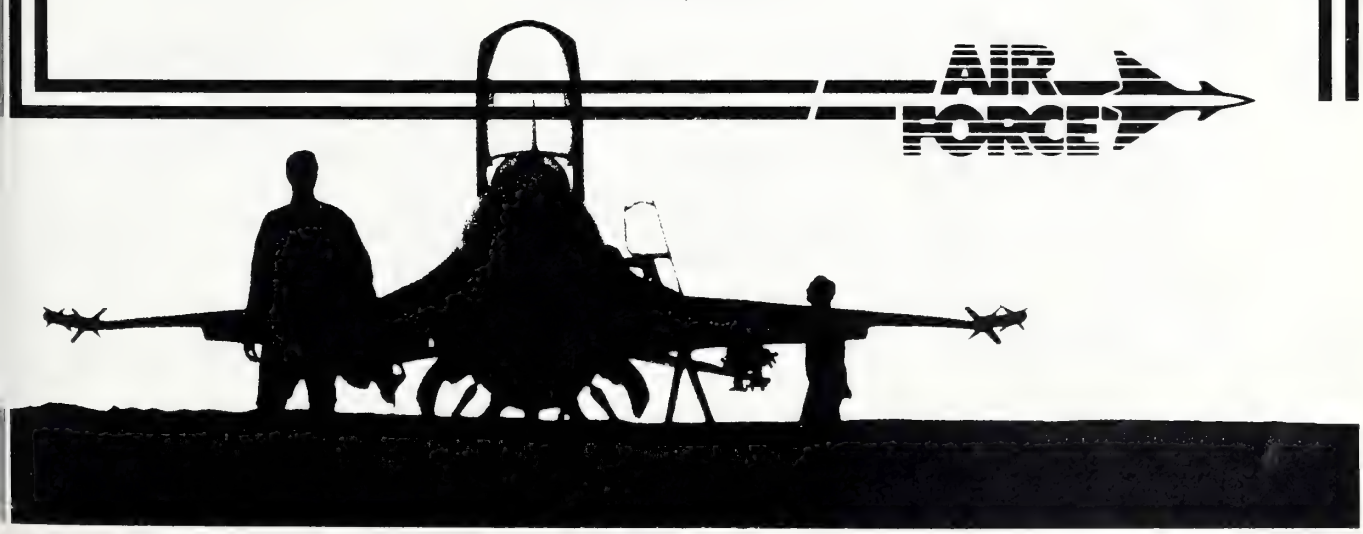
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EKG

(continued from page 272)

Answers: 1. D, E 2. E

The twelve lead ECG showed a narrow QRS tachycardia at a rate of 130 beats per minute. The QRS voltage was increased in the precordial leads for a diagnosis of left ventricular hypertrophy. In addition, there was ST segment depression in leads V_5 and V_6. Careful scrutiny of the baseline showed atrial flutter at a rate of 260 beats per minute, best seen in lead V_1 (marks).

This patient developed atrial flutter with 2:1 AV block, severe hypertension and a tonic-clonic seizure during hemodialysis. This was a medical emergency with hypertensive encephalopathy. Hypertension in chronic end-stage renal disease is caused by excess volume due to salt and water retention or renin-angiotensin related hypertension.

In our patient, nitroprusside infusion was used to lower the blood pressure emergently. Hemodialysis itself can lower the blood pressure by reducing intravascular volume. These two treatment plans successfully lowered the blood pressure. Small doses of digoxin were also given.

Subsequently the patient converted to normal sinus rhythm. Her antihypertensive medication was also increased. Some of these dialysis patients have shown increased plasma renin activity in relation to exchangeable sodium. Some authors have suggested that converting enzyme inhibition may control blood pressure in these patients.[1,2] Our patient did well after her blood pressure was controlled without captopril. ◀

References

1. Delin, K., *et al.:* "Captopril in the Treatment of Hypertension," *Contr Nephrol* 41:299-303, 1985.
2. Lifschitz, M.D., *et al.:* "Effect of Saralasin in Hypertensive Patients on Chronic Hemodialysis," *Ann Int Med* 88:23-27, 1978.

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FAMILY PHYSICIAN: Walnut Illinois. Located in north central Illinois, 2 hours east of Chicago, one hour west of the Quad Cities. Town of 2,000; 6,000 within 10 mile radius. Solo or group (4 other F.P.s in nearby towns). Clinic and other incentives available. Close to 97-bed hospital with good specialty mix. Send C.V. to Bill Spitler, Perry Memorial Hospital, 530 Park Avenue East, Princeton, IL 61356. Phone (815) 875-2811.

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FP(BC/E): Not-for-profit, urban community health center addressing needs of medically underserved, culturally diverse population offers unique practice opportunity. Strong commitment to excellent, accessible, multidisciplinary care and health promotion. Spanish knowledge desirable. C.V. to: Executive Director, Erie Family Health Center, Inc., 1656 W. Chicago Ave., Chicago, IL 60622.

OB/GYN: PHYSICIAN NEEDED For family planning clinic and pregnancy terminations in Chicagoland area. Send resume to All Management Consultants, P.O. Box 2237, Des Plaines, IL 60017.

ILLINOIS. (Chicago, west & central areas): Seeking emergency medicine physicians for full time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

ARIZONA-BASED Physician recruitment firm has quality opportunities coast to coast. Available positions in most primary care and surgical specialties to include OB/GYN, orthopedics, ER, and ENT. "Quality Physicians for Quality Clients since 1972." Call (602) 990-8080; or send CV to: Mitchell & Associates, Inc., PO Box 1804, Scottsdale, AZ 85252.

OB/GYN, ORTHOPEDIC SURGEON, Family practice, general internist, ENT and pediatrician—needed for two-hospital, historic river town of 20,000. Drawing area of approximately 60,000 with new 19,000 acre recreational lake. Unlimited potential. Contact Carol Neil, Physician Recruitment, 623 Broadway, Hannibal, MO 63401 or call (314) 221-3107.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has full-time private practice opportunities for the following specialties: board eligible or board certified internal medicine, and board certified family practice and pediatrics. Positions include income guarantee and no capital investment. For more information, contact Barry R. Trautman, 3663 Lindell, St. Louis, MO 63108; (800) 443-3901.

RADIATION ONCOLOGY: Partnership option. Central Wisconsin on lake. Supported by 2 hospitals with 250K drawing area. Outdoor amenities: hunting/fishing/water sports. Compensation package: 6 figure guarantee plus percentage and full benefits. Board certified with two years experience a plus. Contact Bob, Tyler & Company, 9040 Roswell Road, Atlanta, GA 30338. Collect: (404) 641-6411.

ILLINOIS-SEEKING PHYSICIANS for hospital based industrial medicine clinics. Directorship and assistant directorship available. Attractive compensation and malpractice insurance provided. Contact Emergency Consultants, Inc., 2240 S. Airport Road, Room 17, Traverse City, Michigan; (800) 253-1795; or in Michigan (800) 632-3496.

ORTHOPEDIC SURGEON. An excellent opportunity for an orthopedic surgeon to join a single specialty four-man group that is expanding. Prefer hand or spine fellowship training but will consider general orthopedist. Clinic located within new 300 bed hospital complex. Community offers educational and recreational opportunities. Guaranteed salary and excellent fringe benefits. Send curriculum vitae and letter of inquiry to: Clinic Coordinator, Bone & Joint Clinic, S.C., 425 Pine Ridge Blvd., Suite 300, Wausau, WI 54401. Phone: (715) 842-3202.

GENERAL SURGEON for lovely downstate Illinois community (city 6,000; county 18,000). Growing, progressive hospital with a tradition of excellence. Region offers urban and rural amenities. Guaranteed income practice options available. Contact: Dr. Wendell C. Trent, Memorial Hospital, West State Street, Lawrenceville, IL 62439; or (618) 943-1000 (collect).

CHAIRMAN, DEPARTMENT OF MEDICINE—Mercy Hospital and Medical Center, Chicago, invites applications for chairman of its distinguished department of medicine. Mercy is a major Chicago multi-site medical center with Illinois' longest history of excellence in patient care, teaching, and research. University of Illinois affiliated medical education program, residency programs, and cardiology fellowship. C.V. should reflect outstanding record in academic general medicine, commitment at providing quality leadership, research orientation, publications, experience in program development. Opportunity for limited private practice; salary and benefits negotiable. Submit vitae: John Coleman, M.D., Mercy Hospital and Medical Center, Stevenson Expressway at King Drive, Chicago, IL 60616.

PHYSICIANS NEEDED: Part-time/full-time for family practice, OB/GYN and pediatrics in Chicagoland area. Send resume to All Management Consultants, P.O. Box 2237, Des Plaines, IL 60017.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has part-time and full-time opportunities available for physicians in emergency department, clinic and locum tenens work. Excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman, Healthline Physician Services, 3663 Lindell, St., Louis, MO 63108; (800) 443-3901. We are presently recruiting for emergency departments in St. Louis city and metropolitan area.

ILLINOIS ACADEMY of Family Physicians has available an opportunity service for its members to use. IAFP has detailed information concerning over 150 opportunities of different types throughout the state. To receive complete information, mail your C.V. to IAFP—1200 Harger Road, Suite 722, Oak Brook, IL 60521.

SITUATIONS WANTED

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box #2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DIAGNOSTIC RADIOLOGIST: Board certified, interventional and imaging fellowships, experienced in all modalities, seeks locums short term. Available most weekends, some weeks including weekdays. Reply to Box #2051, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL PRACTICE WANTED: Physician wishes to buy existing general medical practice preferably in DuPage county or nearby. Call (312) 983-0773 after 7:00 p.m.

WANTED TO BUY. General practice or gen-

eral practice with general surgery. Could take over the practice immediately. Reply to Box #2063, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED GENERAL Surgeon seeks suitable position. Willing to do some general practice. Will consider HMO and urgent care centers. Reply to Box #2062, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WANTED PRIVATE GENERAL or internal medicine practice. Chicago or suburbs. Reply to Box #2065, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE, LEASE OR RENT

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)662-1664 or (312) 244-3357.

DES PLAINES. Medical suite in beautiful Lee Street atrium building. Waiting room, reception, offices, two exam rooms. Newly carpeted. Competitive rental plus attractive move-in bonus. Shaker. (312) 524-0800.

USED MEDICAL EQUIPMENT. Complete suites or individual pieces bought and sold. Also examination tables, O.R. tables, O.R. lights, EKG's, therapeutic and diagnostic ultrasound, diathermy surgical instruments, microscopes, etc. Please call or write Robert Shapiro at 2618 W. Peterson Avenue, Chicago, IL 60659; (312) 743-3900.

RENT SUBSIDY: General internist practicing in quaint cottage setting seeks pediatrician, OB/GYN, ortho., ENT, etc, to share space. Located in rapidly growing Lisle. Attractive terms negotiable. (312) 968-2735.

GENERAL INTERNIST. Invest in yourself! One suite remaining in new medical building with numerous specialties now represented. Located in university town in Dunes country of southern Lake Michigan, fifty miles from Chicago. Superior schools, many recreational opportunities, small town atmosphere. Join other physicians now in independent private practice. Achieve your optimum potential by beginning your own practice in this beautiful new building. Complete lab and x-ray. May invest in building or rental available with large subsidies for beginners. Three minutes from 400-bed hospital with all medical facilities. Contact: Thomas J. Covey, M.D.; (219) 462-4167.

FOR RENT: Medical/dental suite located in Hinsdale in prestigious professional building with elevator and spacious parking. 1200 square feet includes 6 rooms plus waiting room and business office. Excellent built-in cabinets, carpeting and tile; some furniture available. Lab, x-ray and pharmacy on premises. Available now at below market rate; (312) 325-6880.

MEDICAL OFFICES and suites available: Lincoln-Ashland-Belmont, Chicago, Illinois. 200-1200 square feet, professional building, elevator, full service janitorial staff, central heat & A/C. Gary Solomon & Co (312) 334-5400.

FOR SALE: Selling pediatric practice and office building, with small apartment in rear of office. 2,042 square feet. $75,000.00 Decatur, IL. Reply to: Box #2064 c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

FOR SALE: ADR 4000 SL Ultrasound machine; price negotiable, Oak Park. (312) 383-9729.

SERALYZER, MODEL 5181. Purchased 1984. Excellent condition. $1750 firm. Call Regina at (815) 933-1980.

CHICAGO, WEST GRAND AVENUE Owner anxious to retire. General practice. Grossing $45,000, asking $25,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL. 60093; (312)441-6111.

FOR RENT: 860 square feet medical/dental office in busy medical/dental/pharmacy professional building, centrally located in Waukegan, close to hospitals. Call (312) 244-0220.

FOR SALE—Family practice by board certified M.D. established 40 years; grossing $200,000 plus. Currently without O.B. with minor surgery. Limitless opportunity for young energetic physician. Town 50,000—15 miles east of St. Louis. Two hospitals supplying coverage in all specialties. Reply to Box #2057, c/o Illinois Medical Journal, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MISCELLANEOUS

PHYSICIANS—EMC*EXPRESS,™ General Electric's electronic medical insurance claim delivery service, is now available. Fully computerized accounts receivable management. Office Resources (815) 664-2567.

MEDICAL PRACTICE SALES and appraisals. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004; (215) 667-8630.

DISCOUNT HOLTER SCANNING Services starting at $35.00. Spacelabs holter recorder (cassette) available from $1275.00. Cardionostic holter recorder (cassette) available from $995.00. Smallest and lightest holters update. Fast service (24-48 hrs turn over). Hookup kits starting at $4.95. Special introductory offer of three free tests with any purchase or lease of the recorder. Cardiologist overread available for $15.00. If interested call (301) 870-3626.

MEDICAL TRANSCRIPTION: Federal disability letters, consultations, progress notes; 24 hour toll-free phone-in dictation service; fast turn-around time; fee per line. Certified Medical Transcriptionists (AAMT), qualified in all specialties. Hagedorn Secretarial Service, Inc., "Specialists in medical transcription"; (312)296-0034.

MEDICAL PRACTICE SALES. At Medidentic we have the expertise and the contacts to sell your practice. Buyers and sellers, see our ad on page 311. Medidentic Practice Sales—(312) 696-0220.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy, (312) 337-4221.

THINKING OF SELLING Your practice? We have cash buyers paying highest prices. Have your practice appraised by professionals. Call or write at no obligation. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312)441-6111.

Matters of Enduring Consequence



Last month, ISMS leadership negotiated an agreement with Illinois' legislative captains. That agreement represented substantial progress in our efforts to ensure quality care for our patients.

Friends of medicine derailed all of the onerous proposals and successfully protected the integrity of the Medical Practice Act. The Act was improved with passage of recommendations by the Task Force on Medical Discipline and the hard-won tort reforms of 1985 survived attack.

The legislative agreement also secured another important facet of medical malpractice reform: a shortened statute of limitations for minors. A three year transition period will precede reduction of the statute to eight years.

It wasn't possible to cap noneconomic losses this year. Only our collective and individual long term commitment will make progress on that front. We will need to work consistently with our elected representatives—and especially through the 1988 election campaigns—to pass caps in 1989.

Our public policy activity has not been limited to malpractice reform. This issue of the *Journal* reflects another crucial public health issue topping the profession's and public policymakers' agendas—the AIDS crisis.

A recent IDPH survey found that 90% of Illinois patients named their personal physicians as important resources for information about AIDS. Our House of Delegates reinforced the role of physician as teacher earlier this year, with a resolution calling for educational AIDS initiatives.

ISMS has attempted to face each issue in this difficult public policy area squarely, and develop consensus on those items affecting clinicians. This month's *Journal* also features opinions and data from clinicians and public health leaders to assist you in counseling your patients.

Last month, I addressed you on the occasion of Dr. Al Goslin's untimely death, and his legacy as ISMS president. In preparing comments this month, I again found that he had left behind a written piece that anticipated our needs.

In his President's Page which was to have appeared in May, Al talked about the importance of maintaining a global perspective. "Our profession has used up a good bit of time, energy and resources fighting the medical malpractice battle," he wrote. "We must not abandon that battle. But we must remember that other societal issues need our attention as well. Speaking out with medical information and expertise can do more than help those in our communities who seek answers to troublesome health care questions. It can also improve the way our profession is perceived.

"Drugs, teen suicide, teen pregnancy and AIDS are commanding media attention and a high level of concern in the public mind right now," he wrote. "Can you be a resource to your local media representatives, community organizations, school health personnel and others on these issues?"

Again, his words offer us a challenge. I hope that the material in this issue helps us to meet it. ◀

Edward J. Fesco, M.D.

Edward J. Fesco, M.D.
President

There's never been a better time for her..



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Proven benefits beyond relief of vasomotor symptoms

No other estrogen proven effective for osteoporosis

Only conjugated estrogens tablets have established efficacy in both osteoporosis[1] and vasomotor symptoms* at 0.625 mg/day. No other estrogen, oral or transdermal, has established clinical evidence or minimum effective dose in both indications.

No estrogen proven safer

PREMARIN is the most extensively tested estrogen, with an unsurpassed record of long-term safety.
And clinical evidence shows a significantly reduced risk of endometrial hyperplasia when cycled with a progestin.[2]

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(conjugated estrogens tablets)

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*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms and for osteoporosis

PREMARIN®
(conjugated estrogens tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(conjugated estrogens)

Vaginal Cream

0.625 mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA
Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea; premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts), nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption, loss of scalp hair; hirsutism, steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance, aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Osteoporosis. Female castration. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart DM, Clark DM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. **2.** Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13

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Memorial Services Held For ISMS President Allan L. Goslin, M.D.

ISMS President Allan L. Goslin, M.D., died May 3, 1987, of an apparent heart attack. Dr. Goslin, who had taken the oath of office only three weeks before, was 50 years old.

A board certified family practitioner from Streator, Dr. Goslin was a founding member of the Board of Governors for the Illinois State Medical Inter-Insurance Exchange and chairman of its Investment Committee.

Dr. Goslin had served as secretary-treasurer of the LaSalle County Medical Society for 16 years and had represented the second district on the ISMS Board of Trustees for 15 years. He had also been a member of the Illinois State Medical Society Political Action Committee. Dr. Goslin had travelled extensively to meet with the media and public groups in seeking reform of Illinois' medical malpractice laws, debating issues and seeking community education.

Dr. Goslin had completed a year's term as ISMS president-elect. In that role, he had chaired the ISMS Planning and Priorities Committee. Under his stewardship, that committee had emphasized enhanced communication with the membership and focused on the Society's educational goals.

A physician friend who spoke at the memorial service on May 7 characterized Dr. Goslin as a humanitarian, a lover of nature, a gentle, accessible, considerate and private person. He was described as someone equally comfortable as a physician, a farmer, a fisherman, a pilot, a cook, and a civic leader. Those present nodded in agreement when he told the story of a busy schedule interrupted to give an airplane ride to a couple of young children.



Allan L. Goslin, M.D.
1936-1987

ISMS Board of Trustees Chairman Alfred J. Kiessel echoed these sentiments in advising the membership of Dr. Goslin's sudden death. "Dr. Goslin was a fine physician and a patient advocate in the strongest sense of the word," he said. "He worked hard in his own medical practice, and through his untiring dedication to civic affairs, he worked to assure high quality medical care for Illinois patients. He worked hard to encourage his colleagues to speak out boldly on health care issues affecting patients. Dr. Goslin was the best kind of leader: he led by example and personal commitment."

Dr. Goslin was a 1962 graduate of Northwestern University Medical School and a former secretary-treasurer and chief of staff at St. Mary's Hospital in Streator. He had served ISMS in many roles, recently as secretary and treasurer of the Hospital Medical Staff Section, as well as chairman of the Finance and Medical Benevolence Committee, Policy Committee, Task Force on Allied Health Practitioners and Health Data Committee. He was a former member of the Board of Directors for the Midstate Foundation for Medical Care, and former secretary-treasurer of the Illinois Valley Chapter, Illinois Academy of Family Practice. His other medical society activities included numerous committee memberships, as well as service with the Illinois Foundation for Medical Care and the Illinois Council on Continuing Medical Education.

Dr. Goslin lived with his wife, Pat, and three children, in Streator.



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(See Brief Summary of Prescribing Information on the next page.)

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

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Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities
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The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

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C85-35 (Rev. 11/85)

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C I B A

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

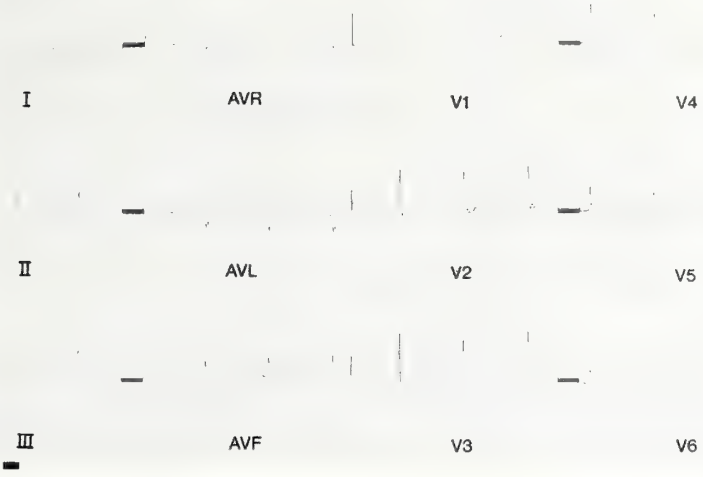
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The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was a 72-year-old man who was admitted to the hospital for evaluation of chest pain and chest tightness. The chest tightness had begun about three months before, occurring off and on throughout an 18-hole game of golf. From that time on, the chest tightness was associated with exertion and always was relieved by rest.

The day of admission, this chest tightness was more severe and was not relieved by rest. In the emergency room, the discomfort was relieved by nifedipine and nitroglycerin. Despite medical therapy in the hospital, the patient had more episodes of chest tightness now occurring at rest, but still relieved by sublingual nitroglycerin.

His past medical history was important only for mild diabetes treated with diet. Physical examination showed a blood pressure of 130/80mmHg, a pulse of 72 beats per minute, normal heart and lung sounds, and a slightly enlarged prostate gland. Chest x-ray showed a normal heart size with a 1.5 centimeter calcified granuloma in the right upper lobe. Admission blood work was normal. This 12 lead ECG was obtained.

Questions:

1. **The twelve lead ECG shows:**
   - A. Complete left bundle branch block.
   - B. Complete right bundle branch block.
   - C. Left anterior hemiblock.
   - D. Left posterior hemiblock.
   - E. First degree atrioventricular (AV) block.

2. **The following statements are true in regard to the management of this patient.**
   - A. Electrophysiologic studies should be recommended.
   - B. A pacemaker is indicated.
   - C. Coronary angiography is indicated.
   - D. Antiarrhythmic agents should be added to the medical regime.
   - E. The diagnosis is unstable angina.

(Continued on page 401)

Dealing with AIDS

The Need for Physician Education

By Richard J. Sassetti, M.D.
Chairman, ISMS Ad Hoc Committee on AIDS

The growing specter of Human Immunodeficiency Virus (HIV) infection and the Acquired Immunodeficiency Syndrome (AIDS) poses serious issues for all segments of society. It has a special impact on physicians.

AIDS is a new entity; our knowledge grows daily. News reports and conversations with patients and colleagues reflect many perspectives and levels of understanding. There is a great need to communicate and share information; that, in a nutshell, is the educational challenge. We are learning but much is yet to be learned.

It is likely that most clinicians will treat a patient for an AIDS-related problem. Physicians are also asked to serve as community resources and "expert witnesses" in development of public policy. In either event, physicians may find themselves in situations where their training is not adequate. And some may feel that their moral or ethical values interfere with their responses as clinicians.

Local, state and federal laws and regulations have been proposed and passed to address the AIDS problem. It is imperative that physicians educate themselves adequately about AIDS-related issues in order to properly serve both their patients and their communities.

Physicians must also be sensitive to the impact of their own moral and ethical value systems (and the potential biases they create) on clinical judgments. For example:

- Can a physician really separate a fear of contracting a fatal disease from whatever homophobia he or she may feel?
- Can physicians objectively ensure that preconceptions about or lack of awareness of AIDS-associated lifestyles do not interfere with adequate history taking to address all potential routes by which HIV can be contracted or transmitted?

Recent surveys indicate that inaccurate perceptions about AIDS are common among physicians. These range from innocent misconceptions about the disease to vigorous homophobic and/or moralistic biases which clearly must color any judgment made by those who bear them.

Physicians who seek to help their patients understand and cope with potential HIV infection or AIDS must be aware of the subtle barriers they may face or perhaps even create themselves.

Three key components enable physicians to deal with HIV infection. He or she must:

- Understand the disease epidemiology with a full grasp of those behaviors which lead to infection;
- Know how to take a history that will elicit the correct information; and
- Be aware of personal biases and understand how these will affect his or her ability to assess clinical needs.

The Illinois State Medical Society has embarked upon an extensive educational campaign to help physicians grapple with the problem of HIV infection and AIDS. A major component of the campaign is a series of traveling seminars presented throughout the state. It also includes a packet of educational material to be mailed to each ISMS member, and an audiotape cassette program.

AIDS-related educational materials targeted to physicians are being developed under a grant from the Illinois Department of Public Health. Issues to be

addressed include:

- Facts about HIV and AIDS and how the infection is spread;
- Preventive measures to check the spread of the disease;
- Suggestions for counseling the patient who tests positive for the HIV virus;
- Preventive measures for health care workers to avoid contracting the virus;
- A discussion of legal and ethical issues surrounding the reporting of a positive test for the HIV virus; and
- A list of HIV testing sites, counseling services, and other available resources.

Illinois physicians need to provide sound, rational counsel to their patients and to communicate with their communities. Members of the public are likely to become increasingly alarmed as AIDS spreads to the heterosexual population. A few general points should be kept in mind:

- Anyone can contract AIDS; it is not limited to the high risk groups;
- AIDS is hard to transmit and readily avoided. This is not a disease that is spread through casual contact. We know how it is spread, and can readily avoid contagion by avoiding the high risk behaviors.

In addition to the grant to ISMS for physician education, IDPH has allocated monies for a companion education program targeted for the general public. That program will be coordinated by a Chicago-based public relations firm. ISMS has worked to assist these efforts. Most recently, the Society mailed a "health tips" column on AIDS to daily and weekly newspapers through out the state.

Patient and community education in so complex a matter will not be easy. Given the high level of trust patients have in their physicians, the medical community has a key role to play. The Ad Hoc Committee will seek to help physicians provide the advice and counsel that is needed. Physicians seeking further information about educational programs scheduled throughout the state are urged to contact the ISMS offices. ◀

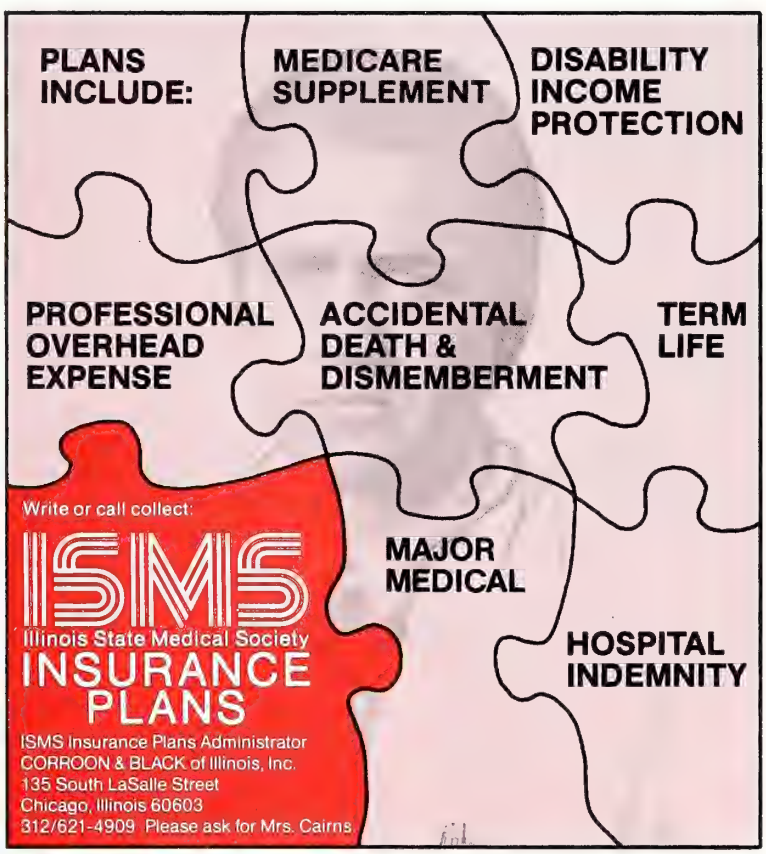
Richard J. Sassetti, M.D., Chicago, is a hematologist specializing in immunohematology affiliated with Rush-Presbyterian-St. Luke's Medical Center as director of the blood center and acting director of the office of consolidated laboratory services. An associate professor of medicine at Rush Medical College, Dr. Sassetti is chairman of the medical advisory committee of Lifesource, a community blood center, and serves as physician liaison to the Illinois Department of Public Health's clinical laboratory and blood bank advisory board. He is chairman of the ISMS Ad Hoc Committee on AIDS, a past president of the Illinois Association of Blood Banks, and a member of the board of directors of Lifesource.

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THE INFORMED PHYSICIAN

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The Value of a Discount

The physician who signs a PPO contract makes a tradeoff. You provide services at established fees and are subject to the PPO's utilization review system. In exchange, you may gain an enlarged patient base and rapid turnaround on claims payment. Although it may be impossible to predict whether this bargain is financially viable for you, certain questions must be resolved before the contract is signed.

What is the established fee?

Sometimes it is a percentage discount off your usual and customary fee. Sometimes the fee schedule is established by the PPO, but the contract does not say how. It could be either your usual and customary fee or the PPO's maximum allowable charge—whichever is less. In a broker-model PPO, the PPO and the payor (insurance company or self-insured employer) are different entities. The contract may provide for a particular compensation arrangement for a particular payor and for the addition of different compensation arrangements as the PPO enters into contracts with other payors. It is important to note the time period for acceptance or rejection of the new payor-specific terms, and whether your acceptance must be in writing. Sometimes compensation additions or revisions are automatically effective if not rejected in writing within 30 days. Your silence is deemed to be acceptance of the new terms. On the other hand, failure to give written acceptance is sometimes deemed to be a rejection of the new terms. Your silence is considered a rejection of the new terms.

If you can, bill the contract patient directly for co-payments and deductibles; this amount is generally subtracted from your fee. Some contracts specifically allow you to also bill contract patients for services which are *not covered* by the plan. Under some systems, you may bill the patient who requested—in writing—*a covered medical service* for which the PPO utilization review denied authorization.

Frequently, contracts provide that failure to comply with utilization review policies and procedures may result in fee reduction or denial. In this regard, it is important to remember that although the contract establishes the economic and legal relationship between you and the PPO, it does not affect the "standard of care" which defines your duty to your patient. The legal and ethical responsibility for good medical judgment remains with the physician. It does not shift to the review organization. Your "standard of care" is not diminished by cost containment programs. (See May 1987 *IMJ:* "Authorization Denied—Payment Refused," and March 1987 *IMJ:* "Reading Between the Lines.")

Can the PPO change your fee?

Some contracts give the PPO the right to unilaterally change the fee schedule. Other contracts provide for periodic review of the fee schedule but do not define the period. Is it quarterly or twice a year? What factors are considered in the review? Are the physician's performance, economic indices, or the profitability of the PPO determinative? When a contract provides for a fee increase if actuarially justified, it is necessary to know what actuarial assumptions are used and what is meant by justified. Sometimes the PPO has the right to change the fee schedule for the following contract year by giving the physician notice 90 days before expiration of the current term. In this instance, you should check the termination clause to determine if this will give adequate time to consider the PPO offer. The termination clause will

tell you how many days' notice you must give the PPO in order to terminate the contract. (See January 1987 *IMJ:* "In Search of An Exit.")

Does the PPO guarantee payment within a specific time?

The PPO's promise of prompt payment is frequently an unenforceable illusion. Consider these provisions. "PPO will *use its best efforts* to make payment within 30 days of receipt of *approved* claims which are *properly* completed."

First of all, a promise to use your best efforts is no guarantee of performance. Secondly, how much time can the PPO take before it approves a claim? Under this provision it has 30 days after it approves a claim to use its best efforts to pay it (if, that is, the claim is properly completed). What is meant by "properly completed?"

By now you can easily imagine the possible delays. Some prompt payment provisions have teeth. If the PPO must either pay the physician's usual and customary nondiscounted fee or a finance charge if payment is late, it's more likely that payment will be prompt. If a claims dispute leads to an audit, it is more likely that the audit will be completed promptly if the PPO must pay nondiscounted rates when the audit continues beyond a fixed period.

In broker-model PPOs, prompt payment questions may have an additional twist. Consider this one: "Physician must submit claims to the PPO within 30 days of rendering services and payor must pay the bill within 15 days of receipt of the bills from the PPO." How long will it take the PPO to process the claim before it sends them to the payor? Or "Payor agrees to pay PPO within 30 days of properly completed claim forms." When will the PPO pay the physician?

Will the contract increase your patient base?

Contracts do not guarantee the physician any minimum or maximum number of patients. Some contracts make no mention of marketing but simply provide that beneficiaries shall have economic incentives to seek services from PPO physicians. What are the economic incentives? The type and level of economic incentive may determine the volume of patients you see from a PPO. Some contracts obligate the PPO to actively market the plan. What percentage of the PPO's budget will be spent on marketing?

Because you're an informed physician, who recognizes the complex issues involved in contracts for the delivery of medical care, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the Office will provide you objective comments on any HMO, PPO or IPA contract at no cost. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the Office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

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Student Impairment Seminar

By Jack M. Whitney, Chair of ISMS-MSS

On Saturday, April 11, 1987, the Medical Student Section of the ISMS held its Spring Seminar on the subject of "Student Impairment." Don Sellers, M.D., medical director of the Parkside Lutheran Hospital and a specialist in chemical dependency, and Steve Haught, the EAP coordinator for Lutheran General Hospital's Residency Assistance Program (RAP), led a two-hour discussion between thirty members of the Medical Student Section on epidemiology, diagnosis and treatment of chemical dependency, and other types of impairment in medical students, resident physicians and practicing physicians.

Review of these topics at the semi-annual open meeting of the membership was prompted by a discussion at the AMA-MSS Assembly at its December meeting in Las Vegas on the appropriateness of drug testing for physicians and medical students, as well as several articles describing the prevalence and patterns of the psychoactive substance use by medical students over the last year. The September 25, 1986 issue of the *New England Journal of Medicine* described the results of a survey of 500 active physicians, 510 pharmacists, 504 medical and 470 pharmacy students.

Fifty-five percent of the responding physicians and 78% of the medical students reported use of psychoactive substances at some time in their lives. Twenty-five percent of the physicians reported current self-treatment with psychoactive drugs. Thirty-nine percent of medical students described recreational use of psychoactive substances. The authors concluded that recreational drug use by physicians and medical students reflects current trends in recreational drug use throughout American society. Preventive efforts should focus on marijuana and cocaine use by medical students and opiate and tranquilizer self-treatment by physicians.

Dr. Sellers began the seminar with a videotape produced by the Medical Association of Georgia, producer of a pioneering physician impairment program. This video demonstrated the technique of intervention, whereby an impaired physician is confronted by members of the Medical Association Impairment Committee and, in conjunction with the physician's colleagues, family and co-workers, outlines the pattern of social and behavioral dysfunctions which mark the transition from substance abuse to chemical dependency and impairment. Following the videotape, Dr. Sellers emphasized that dependency and impairment are characterized by loss of control, impairment of social or occupational function and continued use, despite injury or impairment.

Steve Haught then described the Employee Assistance and Resident Assistance Programs promoted by Parkside Medical Services and provided at sites throughout the country. These programs offer employers, residents, employees or their families access to evaluation and referral services for emotional, financial, legal, family, alcohol, drug or stress related problems. When access is initiated by the individual, absolute confidentiality is maintained. When referral is made by an employee, only attendance for evaluation and referred treatment may be reported without the specific release of records by the individual being assessed.

Dr. Sellers continued by describing the treatment program, which is initiated by a four-week detoxification admission followed by a two-year program for individuals with chemical dependency. For impaired professionals accepting referral into this type of program, approximately 70% will maintain abstinence for this two-year period.

Finally the last segment of the program reviewed the impairment program sponsored by the Illinois State Medical Society. A survey of the pattern of drug and alcohol use in a single Illinois medical school was reviewed by Jack Whitney, Chair of ISMS-MSS. Further discussion was made on differentiating substance abuse from chemical dependency and impairment in the medical student population, many of whom may demonstrate behavioral dysfunction secondary to the stress and sleep deprivation which are integral to their clinical experiences. Dr. Sellers reemphasized the point that dependency and impairment are characterized by a pattern of increasing social and occupational dysfunction. He also encouraged the formalization of "gripe" sessions and critical review of students' and residents' clinical experience to allow ventilation of grievances and identification of program abuses and stresses.

The number for confidential access to the ISMS Impairment Program is 312-580-2499. ◀

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

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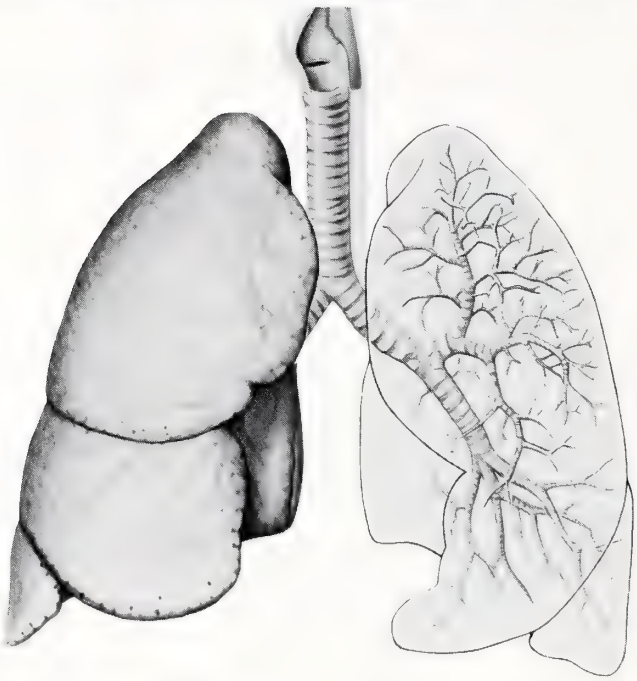
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- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
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Announcing the 1987 Physician Games

The 1987 ISMS Physician Games will be held Friday & Saturday, August 7-8, 1987, at Marriott's Lincolnshire Resort, Lincolnshire, Illinois, just 40 minutes north of Chicago.

The Physician Games will again offer competitions in tennis, racquetball, golf, track, volleyball and basketball. In addition, this year the Games will offer a golf pitch-and-putt clinic late Friday afternoon, health and fitness seminars for non-competitors, and children's activities.

Special events will include the Friday night reception followed by a presentation on "Footware and Foot Injuries;" the Saturday "Health & Fitness Luncheon" featuring a national expert on child health; and the concluding Awards Banquet with a celebrity speaker and dancing.

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  Reception/seminar
- ☐ Saturday
  Children's events (List children's ages: _____)
- ☐ Saturday morning (7:00-10:00 a.m.)
  Track, golf, racquetball, tennis
- ☐ Saturday afternoon (1:00-4:30 p.m.)
  Volleyball and basketball team events
- ☐ Saturday night
  Awards banquet

Return to ISMS Physician Games, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

A Brief Summary

ISMS Actions Regarding AIDS

The ISMS Board of Trustees and House of Delegates have considered matters relating to the AIDS crisis, seeking to formulate reasonable directions to protect the public health.

Actions by the ISMS leadership have centered on issues related to blood donation, confidentiality, contagion and education.

The ISMS policy manual includes a formal statement calling for ISMS education of physicians and patients regarding the inability of contracting AIDS by donating blood. The policy also specifies that designated donations are an inappropriate means to deal with the AIDS problem.

Other actions by the ISMS Board of Trustees and House of Delegates, while less formal than official policies, provide a sense of the Society's direction. In September, 1986, the Board of Trustees commented on look-back campaigns and antibody testing.

Look-Back Campaigns

ISMS supports the concept of "look-back" as a means of protecting patients and reducing the possible spread of disease.

When a physician is notified that one of his/her patients has received blood from a donor who is now known as being Western Blot positive, the doctor should:

—promptly notify the patient of the need to visit the office to discuss a medical condition;

—advise the patient in a confidential and personal fashion of the situation;

—offer to perform an HTLV-III antibody test; and

—be prepared to provide social-psychiatric support and referral to an infectious disease specialist.

In conjunction with their hospitals and local blood centers, medical staffs should develop policies and procedures for determining which physician should be contacted about a patient who received such blood and who should be responsible for notifying the patient.

Information related to Western Blot positive donors and patients who received blood from such donors should be strictly confidential and maintained as such by all individuals privileged to such information.

AIDS and Antibody Testing

Physicians should provide competent and humane care to all patients, including those with critically ill conditions such as AIDS and AIDS-related conditions.

Upon request, the Society will provide information to its members on the many issues and developments related to AIDS. This will include information on resources and specialists available to AIDS patients, so the physician can educate himself and others about the disease and the HTLV-III virus, and the limited mechanisms by which the virus is or can be transmitted.

Testing for the HTLV-III antibody should be used only in situations which benefit individual patients and the public health.

Counseling and educational efforts, rather than policies promoting physical restriction and isolation, are appropriate primary methods for controlling the spread of AIDS and HTLV-III infections, until further information suggests otherwise.

The privacy of patients infected with the HTLV-III virus should be protected.

Physicians should incorporate into their practices standard procedures for taking complete sexual and lifestyle histories of their patients and should assume responsibility for educating their high-risk patients about the need to modify behavior which places the patient at risk for HTLV-III infection.

ISMS should support continued research into the causes, prevention and treatment of AIDS and AIDS-related conditions.

Contagion and Education

The ISMS House of Delegates voted at its 1987 annual meeting to take formal action endorsing the Center for Disease Control's current "Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace," and to make that document available to hospitals and hospital medical staffs upon request.

The House directed that the Board of Trustees develop public position statements and encourage physicians to educate patients and communities on public health issues pertaining to contagion in all population groups. They also mandated an AIDS Alert to the media, encouraging preventive education

for all demographic segments, with particular emphasis on teens and young adults.

Ongoing Educational Efforts

In November 1985, the Board appointed an Ad Hoc Committee on AIDS to review legislation and make recommendations on developing issues. The Ad Hoc Committee has coordinated ISMS educational efforts, and is now working to implement an IDPH grant for physician education.

The physicians on that committee are developing a packet of informational materials and also scheduling ISMS AIDS seminars throughout the state. The St. Clair County Medical Society in Belleville, Springfield Clinic in Springfield and Passavant Memorial Hospital in Jacksonville have all scheduled programs for this summer and fall. Medical groups interested in scheduling AIDS seminars are encouraged to contact the ISMS offices. ◂

CDC Guidelines Regarding AIDS Contagion in the Workplace

In April 1987, the ISMS House of Delegates adopted guidelines issued by the U.S. Public Health Service Centers for Disease Control with respect to AIDS transmission. The "Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace," are comprehensive guidelines, available upon request from ISMS. Brief highlights are offered below.

The CDC issued updated guidelines regarding HTLV-III/LAV transmission in the workplace on November 15, 1985. The information is particularly relevant to health care workers.

The document, while lengthy, is precise and specific; these highlights are not intended to replace it.

The CDC has found that HTLV-III/LAV is similar to, but far less transmissible than, hepatitis B, and that standard procedures to prevent HBV infection are appropriate to HTLV-III/LAV. They do not recommend routine screening of health care personnel for infection, instead focusing on proper handling of blood and body fluids or items soiled with either of those.

The greatest risk involves parenteral exposure to a contaminated needle or other sharp instrument. Specific provisions for follow-up in that event are provided.

The CDC recommends five specific precautions to avoid infection in the workplace:

- ☐ Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.
- ☐ Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
- ☐ When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.
- ☐ To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.
- ☐ Pregnant health care workers are not known to be at greater risk of contracting HTLV-III/LAV infections than health care workers who are not pregnant; however, if a health care worker develops HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection resulting from perinatal transmission. Because of this risk, pregnant HCWs should be especially familiar with precautions for the prevention of HTLV-III/LAV transmission.

The CDC has also promulgated recommendations for home care and prehospital emergency health care. Consideration is given the possibility of transmission from a health care worker to a patient. Procedures for sterilization, disinfection and waste disposal of contaminated materials are identified. Considerations for other "personal service workers," such as persons who provide tattoos, ear piercing and acupuncture, are included. ◂



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IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 171, No. 6
June 1987

Clinical Treatment of AIDS

Waiting for the Other Shoe to Drop

It is likely that most primary care physicians will come in contact with AIDS patients. In an effort to explore the clinical picture, IMJ *recently visited two infectious disease specialists who are treating AIDS patients in Illinois.*

IMJ: *What are the chances that an AIDS patient will present to a family physician or other primary care doctor?*

Dr. Graham: I think almost everybody is going to see AIDS in some form or another. In a city like Chicago, of course, the chances that a doctor would encounter AIDS must be close to 100%. In a city like Springfield, the chances could be as high as 25%.

Dr. Malow: The chances are going to increase as the disease continues to spread and make itself more apparent. There probably are cases out there that are being missed because physicians are failing to recognize the syndrome. They have not had experience in recognizing all of the ways in which the disease can present itself.

We can't be naive in our understanding of what goes on in the real world. As long as you have men who are bisexual and continue to have relationships with men and go home to their wives at night, as long as you have people who frequent prostitutes, as long as you have people who will use intravenous drugs, the disease will continue to spread.

IMJ: *How are physicians reacting to AIDS patients? Are there any problems with physicians avoiding such patients due to fears of contracting the disease or a disapproval of the types of lifestyles that usually accompany development of AIDS?*

Dr. Graham: It's certainly true that we have physicians who won't see patients with AIDS, who would decline to perform an operation, or who would—for one reason or another—decide that they wouldn't feel able to take care of a patient with AIDS.

There also are people—including physicians—who don't agree with the lifestyle of those patients who have contracted AIDS or an HIV infection. But we haven't had any trouble in providing care. Many of these people require many specialists, but I can always find someone who is appropriate for the disease to take care of them.

Dr. Malow: It's not a problem at Illinois Masonic simply because we've seen enough cases to be aware of the disease and people are comfortable in dealing with it.

On the other hand, in other hospitals where I've seen patients, there certainly is a fear and a lack of understanding among physicians and ancillary health care people. For example, there are unnatural fears with regard to potential acquisition of the disease. And there is going to be difficulty unless we continue to educate people and let them understand exactly what they're dealing with.

IMJ: *What about other health care personnel in the hospital? How are they reacting to AIDS patients?*

Dr. Graham: I have found that the



James Malow, M.D.

We can't be naive in our understanding of what goes on in the real world.

nurses are very receptive to education. They're reassured by it, and they learn from it. They then walk into the patient's room and offer the best care to the patient and seem unconcerned about the type of disease or what led up to it.

As an example, we had a patient who was transferred from a state prison with AIDS. He was brought directly to the intensive care unit by helicopter, so there wasn't a lot of time for preparation. The intensive care nurses were all rather frightened about it, so we had an emergency in-service session for them.

We told them how to handle the secretions and to wear gloves and watch for any bleeding lesions. The next day there seemed to be a general wave of relief that this was a safe patient to take care of. He made it, and everybody was very happy about the fact that he survived, and did well, getting ideal care.

Dr. Malow: I think every institution that has dealt with AIDS patients has dealt with a variety of unusual problems, be it that security wouldn't come up and take the patient's valuables, an individual refused to enter the room, or people overdressed and put on gowns and masks when it was inappropriate.

These problems are going to occur. And again, the best way of handling it is education so that people understand the potential risks and how best to protect themselves.

IMJ: *What potential means of transmission of the HIV virus pose a risk to physicians and health care workers?*

Dr. Graham: The main thing to watch out for would be a needle stick. It's possible that there would be some bleeding that would fall onto an open cut or some sort of open skin lesion and that blood might seep into the skin. There's also a possibility of aerosolization of the blood—for example, if a patient has bleeding coming from the lungs and he coughs, that might get into the air and perhaps into the face of a nurse.

These things are usually anticipated and can be ducked, but the needle stick is the number one source of concern. We've had numerous educational campaigns about needle sticks and they work, but they don't work very well. I think people get casual about needles. They don't think that needles can cause them any problem.

In general, they haven't caused problems with AIDS and that may reinforce this casual attitude. But there does appear to be a small—very small—risk.

Dr. Malow: One has to take somewhat conservative measures to avoid any contamination, especially by blood and blood products. If you're going to be drawing blood on a patient with AIDS, then it is appropriate to wear gloves. And if there's going to be any aerosolization of bloody fluids—for instance, doing dental procedures—then it is going to be appropriate to wear gloves, goggles, a mask, and perhaps a gown to protect yourself.

Certainly, if you're doing a surgical procedure, you may consider double gloving as a means of protecting yourself.

Transmission of the disease has to be a matter of contamination by body fluids or by blood and blood products. Shaking hands with somebody is no risk. Talking to someone is no risk. Sharing the telephone with someone is no risk. Eating off of the same plate is no risk. You need much closer contact.

IMJ: *We've talked about the attitude of physicians and health care workers toward AIDS patients. But what about the reaction of other, non-AIDS patients in the hospital? How much of a problem has this been?*

Dr. Graham: I think there would be reluctance on the part of many patients to share a room with an AIDS patient. But if you explained that AIDS is not transmitted by sharing space in the same room, I think most people would accept it.

In my office, I have some patients with AIDS who share the same wait-

ing room with children, and with adults who don't have AIDS. There hasn't been any reluctance by non-AIDS patients to occupy the same waiting room, so I don't think we're running into too much trouble.

Dr. Malow: Patients have a very high level of awareness about the risks of acquiring the HIV virus as a result of blood transfusions. It's an ever-present question in peoples' minds. And I think there's been a very marked attitude change among people receiving blood, platelets or other blood products.

In spite of the fact that it's quite safe now with screening, the reluctance is still there, and people are hesitant about blood transfusions. There is more auto-transfusion in elective procedures, where the patient's own blood is drawn and used as needed.

IMJ: *How do we go about lessening patient fears with respect to receiving blood transfusions?*

Dr. Graham: We should show them the statistics. In Sangamon County, statistics about the number of units transfused and the number of infections following transfusions are published regularly. And, of course, we also check the blood before it's transfused.

I think if you keep hammering home that lesson of safety, eventually it will take. And that has to be done, not only on a broad public scale, but by the physicians and the nurses who are dealing with the transfusion at the time.

Dr. Malow: I don't think people should be totally relaxed about blood transfusions or blood products. I think that there must be strong indications for using them. If it's indicated and you need it for a life-sustaining problem, then you're going to have to give it regardless of the risks. On the other hand, if it can be avoided, I think that it should be avoided.

There is still a greater risk of acquiring non-A and non-B hepatitis from blood transfusions, for which we have no screening. And that can be a fatal disease—not as often as AIDS, but it can be a very serious illness. So a blood transfusion is not benign, and we have to use good judgment about who needs it.

IMJ: *Let's discuss the AIDS patients themselves for a moment. How do most patients react when they learn from the physician that they have the disease?*

Dr. Graham: Usually they know it. They often have been facing the prospect of carrying the virus for a long time before they even come in to see me.

I see a lot of people on referral,

AMA Recommendations for Persons in Contact with AIDS Victims

The American Medical Association has developed a series of monographs on AIDS, which include guidelines for persons in contact with AIDS victims. Following are some recommendations regarding AIDS contagion for family, friends, and other persons who may come in contact with victims of the disease.

There is no evidence that family, household members, or close contacts can contract the disease by routes other than exposure to blood, sexual relations, or perinatal transmission.

Reasonable precautions should be taken within the household to avoid direct contact with blood and other body fluids. However, these precautions need not interfere with normal interactions.

There is no evidence that saliva on household items can transmit infection. Household items may be shared by patients and household members. It is not necessary to have separate dishes and eating utensils for AIDS patients, although they should be washed routinely with hot water and detergent.

Razors, toothbrushes, or any other items that may be soiled by blood from the AIDS patient should not be shared.

Blood and other body fluids (urine, feces, or items soiled by blood and body fluids) should be handled with care. Disposable gloves should be used and hands should be washed thoroughly with soap and water. Soiled surfaces should be cleaned with a solution of household bleach diluted 1:10 in water.

Bathroom facilities (toilet, bathtub, and shower) can be used by all household members. Facilities should be kept clean, and soilage by body fluids should be cleaned with household bleach diluted 1:10. Blood and other body fluids can be flushed down the toilet.

Soiled clothes or linen should be washed with a detergent and/or bleach.

Sharp objects used in the home care of patients should be handled carefully to avoid accidental injury and disposed of in impervious sealed containers. ◀

and, of course, they've had a chance to think about it for a while. Or sometimes a physician calls me and says, "I have a patient who's positive, and I'm not sure I know everything to do," and I'll help to break the news.

People occasionally come in without a physician referral. They, too, usually know that they carry the virus, and I'm really amazed by how much they know. We don't give our patients enough credit.

Dr. Malow: The effect on people is quite variable. I think that's just human nature. Some people become exceedingly depressed. Individuals have become suicidal or developed acute psychiatric illnesses. And there certainly are reports in the literature of people who have committed suicide after learning that they have AIDS, AIDS-related complex, or HIV infections.

Patients at times may be angry, and they sometimes express their anger in a violent way. Other people have been very reasonable in the way they've handled it, especially those who are just HIV infected.

I've also seen a lot of homosexual men who have become celibate and have just said, "If that's the case, then I'm just not going to have any sexual intercourse anymore so that I cannot expose anybody to the virus."

IMJ: *What about the person who tests positive for the HIV virus but has not yet developed AIDS? How should the physician go about counseling such a patient?*

Dr. Malow: It is the obligation of the physician to break the news to the patient and give the patient a full understanding of the potential consequences.

The most recent data shows a 50%-70% chance that somewhere down the line the person is going to become ill. That's kind of scary, but it's reality, and they have to face up to it.

Additionally, the person should be advised of the risks to people they associate with. They should have a clear understanding of what may occur as a result of their behavior. They must be told that, if they are going to continue to have sexual relations, they can transmit the disease via sexual secretions.

If they are going to continue sexual relations, they should be told that protected sex is necessary. That means using a condom.

Patients also should be told not to share anything that comes in contact with blood or blood products. That means toothbrushes, razors, and things along that line. And certainly, they cannot donate blood or blood products of any kind.

IMJ: *We've talked about counseling people who might test positive for the HIV virus but show no symptoms. Who are the people likely to present to the primary care physician seeking a test for the virus?*

Dr. Graham: They are members of several groups: somebody who had visited a prostitute sometime in the past; somebody who had some homosexual affair or single encounter; someone who had received a blood transfusion.

Also, someone who had used drugs in the past—usually someone who had used drugs but has quit. Those who continue to use drugs often are not too concerned about it.

In general, the people with one, two, or three potential exposures worry. Another group we're seeing are women who have had intercourse with men whose backgrounds they weren't quite sure of. We're actually seeing a larger number of women who are worried about AIDS, either because of concern about their husbands' previous activities or their own. They just want to be sure.

IMJ: *How do you feel about mandatory screening programs designed to detect the HIV virus, such as premarital testing or checking all hospitalized patients?*

Dr. Graham: Testing routinely for all hospitalizations is going to lead to overtesting of a large number of people. You see a lot of people with heart failure, diabetes, and other chronic illnesses who continually enter hospitals. They're going to be tested repeatedly, and most of them are such low risk that there's no reason to test them in the first place. So I don't recommend routine testing of all hospitalized patients.

I also don't recommend testing of all premarital couples. First of all, once I have the information, I'm not sure that I could prevent the marriage. I don't know if that's a legally sound move. I also don't know if, in these days when premarital sex is not rare at all, we would have stopped anything. And the two may decide that they want to get married anyway.

In general, with premarital screening, you're dealing with a group that is very low risk, and you're going to spend so much money testing them that you will have exhausted whatever budget you have for control of the disease.

Dr. Malow: I'm not so much against mandatory screening. I'm much more concerned about the rights of the individual afterwards. And I think that we're going to see legislative developments in that area.

We may see some very interesting changes in terms of our legal system, especially as the disease begins to grow among heterosexuals. I think we're going to see multiple changes, such as insurance companies requiring HIV testing before issuing health care or life insurance policies. These questions are going to come up and will probably be challenged in courts across the country.

IMJ: *But given the uniformly fatal nature of the disease, have we reached the point where public health concerns should outweigh those pertaining to confidentiality?*



Donald Graham, M.D.

Instructing a patient in "safe" IV drug use can run counter to your grain. But you realize that the patient isn't going to stop the behavior, so you try to be realistic and limit the damages.

Dr. Graham: I don't think we're there. I don't see any point in maintaining any public lists. Anybody is subject to blackmail, and no matter how many problems they have, it could get worse.

On the other hand, you have to ask what the public health requires. Why do they need a list like this? Is it going to be to try to prevent the spread of disease? If so, we already have the techniques to prevent the spread. Driving home the lessons about behavior will do a lot more than trying to trace every contact after it's happened.

There are, however, civil liberties questions. What about the prostitute who refuses to quit work? What do you do there? There we have a very well-defined, high-risk activity, that is illegal to begin with. Those people ought to be subject to law enforcement.

IMJ: *This gives rise to the issue of quarantine for AIDS patients. Is that a possible solution?*

Dr. Malow: That's totally unreasonable. Quarantine makes no sense at all, because if you've got 30,000 AIDS patients, you may have up to three-million people out there in society already infected.

The AIDS patients are identified. You know who they are. It's a lot easier to deal with those patients and say, "OK, we instruct you in terms of what your behavior is." They are not the major risk to the rest of the society.

The risk is the person who feels perfectly fine but is infected and is going out and spreading disease throughout society. That's the person I'm concerned about. AIDS patients, once they're identified, usually are not going to go back and become sexually active. They're not going to donate blood.

IMJ: *Education is our only tool in dealing with the threat of AIDS. But many physicians find it difficult to discuss such subjects as "safe sex"—particularly with their younger patients. Is the threat of AIDS so serious as to justify asking physicians to put aside their personal moral beliefs?*

Dr. Graham: The surgeon general would say that it is. For the first time in memory, the surgeon general has gone on the stump. Even when he came out against smoking, it was by means of a report and a few press conferences. He didn't go out campaigning.

But now, he is taking the message out. He's getting publicity. People are listening to him. And he's saying, "Yes, you're going to have to swallow some of your personal moral beliefs and recognize the facts of life—that there's a lot of behavior out there that could be high risk, and like it or not, you don't want it to get worse by having your patient get AIDS. So you should warn them about how they can prevent AIDS."

The Surgeon General is a reasonable man. His statement is reasonable. And I think—when read in the context which he intends—most people can appreciate that statement, and they can accept it.

It can be uncomfortable for a doc-

tor to talk about things that he doesn't agree with. Instructing a patient in "safe" IV drug use can run counter to your grain. But you realize that the patient isn't going to stop the behavior, so you try to be realistic and limit the damages.

Most physicians appreciate the problem of alcohol. They tell their patients, "try to eat a full meal when you have your binges," while at the same time telling the patient that alcohol is bad for him or her. They accept the fact that their patient is going to drink alcohol, and just try to make it easier on them. I think the same is probably true in terms of adjusting your thinking for AIDS.

Dr. Malow: I think it is important for us to shift gears a little bit in terms of our approach to patients, although we may be stepping on foreign ground. A young individual who comes in with a nonspecific illness has to be asked about his or her sexual history. I think that has become very important.

When your patient is a businessman that you've known for a long period of time, and he's married and lives in the suburbs and has three or four kids, it's tough to turn and ask if he's a homosexual when he comes in with a funny kind of pneumonia. But you have to overcome that barrier. You may be stepping on a very touchy situation, but the questions have to be asked.

But I don't think the onus of responsibility lies solely with the physician. I think the responsibility lies across the board. So if the physician is a weak link because he's not as knowledgeable as he should be, there should be some backup.

There should be commercials on TV. There should be general educational material in terms of magazine articles and newspaper articles, as well as education in the school systems. And I know that, especially when we've had to deal with an HIV infection in a school, the physicians have jumped in and played a major role in trying to get people to deal with this in the proper fashion.

The risk is the person who feels perfectly fine but is infected and is going out and spreading disease throughout society. That's the person I'm concerned about.

IMJ: *Let's again turn back to patients who are suffering from medical conditions associated with AIDS. What is it like to treat AIDS patients?*

Dr. Graham: It's bad. It's depressing to be without hope, to have to say, "Well, maybe we can prolong your life or maybe we can treat this infection, but yes, you'll still have AIDS. Maybe you can take this $10,000-a-year prescription that might cause anemia, and we can prolong your life."

It's even worse when the patients go to the hospital with their infections, and people begin to quit visiting them. Some families are very supportive. Others reject the patient.

Sometimes, most of the family supports the patient, but some don't. And sometimes, the patient doesn't have a family. A lot of homosexuals, of course, don't have any children and aren't married. Sometimes their parents or their brothers and sisters aren't alive or in the area.

Many of these patients are really alone. They may have the support of their lovers or some community group, but it's a very lonely disease.

The needles are bad; the drugs are often toxic. It's embarrassing and tiring to have all the diarrhea, and pneumocystis pneumonia is very frightening.

Sometimes they need intubation, and, of course, that's always frightening to anybody. Sometimes they need lung biopsies, which are scary to say the least. And all the while, they know they're going to die anyway.

So it's bad. We have support groups. We have task forces. But they're very limited in what they can really offer the patient because they can't cure.

AIDS patients go through the same stages as patients who are dying of any other disease. Although they suspected that they had it, they still deny it, and they're angry.

Sometimes they turn on the doctor, nurses, or lab techs. And sometimes they go on to the dementia, and that makes it more difficult because you can't really reason with them.

Dr. Malow: From the standpoint of an infectious disease specialist, it's kind of interesting that those of us who went into this field were excited because it was one of those fields that, in most cases, dealt with curable diseases. If you gave antibiotics to the patient with pneumonia, they could get better. If you dealt with a parasitic disease, you could give the patient some type of drug, and they could get better. Fevers of unknown origin were challenges, and very often, you could find something like tuberculosis or fungal disease. And again, when treated, they could get better.

We didn't choose to go into oncology, and we didn't choose to go into nephrology. We didn't relish the idea of treating people who were chronically ill. And suddenly, AIDS has come along, and now we are dealing with chronically ill patients who have an ultimately fatal type of illness.

It's been a challenge, a frustration,

and certainly, AIDS patients are not the kind of patients that infectious disease specialists have been accustomed to treating.

It's also difficult in that most of the patients tend to be young, previously healthy individuals who come in and, over a couple of years and maybe a couple of months, waste away and die. Many of them are very bright, vital individuals. You just watch them dissipate over time.

It's a depressing situation. There are small victories that take place along the way—when you're able to treat illness and maintain patients at a reasonable level of health. They function always waiting for the other shoe to drop, knowing that something else is going to pop up along the line.

AIDS also is a unique disease with regard to some of its social aspects. If you see a patient who acquires cancer, the general response from the rest of the family is to rally to the bedside and support the individual through everything that's done. In the AIDS population, especially among the homosexuals, we have seen some very unusual situations that just add to the tension of treating this disease.

I've seen multiple cases where people have become ill, and families are nowhere to be found. They alienated the individual because of his homosexuality 15 or 20 years ago. Or a guilt-ridden family now comes back 15 or 20 years late to sit at the person's bedside. There's a tremendous amount of anger or guilt that just runs right through the entire family.

It becomes much more than just treating the patient. You're treating a whole emotional family process as they reunite and deal with these issues.

There have been additional problems with long-term support and placement of AIDS patients or those with AIDS-related complex who are too ill to go home. They need to be placed somewhere and taken care of in a nursing home or extended care facility, and no place will take them. Many of them end up staying in the hospital long-term.

IMJ: *Overall, speaking as an infectious disease specialist, how scary is the current AIDS epidemic to you?*

Dr. Graham: I think it's very scary. But it shouldn't be as scary as we sometimes make it, because, fundamentally, we can prevent AIDS. I can prevent AIDS with education better than I can prevent an automobile-associated accident with seat belts. That should be reassuring.

But there are some people who have AIDS and aren't going to take the proper measures to prevent its spread, and there are some people who got it before there was any recognition that there were ways to prevent it. So one way or another, I'm going to be involved. I have to be very involved. Everybody's going to be involved either directly or indirectly in the years to come.

Dr. Malow: I, too, think it's very scary. The writing is on the wall. We are definitely going to be seeing a steady increase in volume with time. And I think it's also scary from the standpoint of trying to predict what the public reaction will be.

What is going to be the reaction of the public as we see more and more heterosexuals involved with this illness? That scares me a little bit.

I'm not sure how reasonable people are going to be when the guy down the block comes down with AIDS. They won't be able to tell themselves that AIDS only happens to drug addicts.

I think that when we start to see it more and more in the heterosexual population, and don't have a definite risk group to attach it to, we're going to start to see a very high degree of fear. This emphasizes the need to educate people so that the general public is sophisticated about the problem and it's less likely to cause a tremendous panic as cases in the general population increase. ◀

There are small victories that take place along the way—when you're able to treat illness and maintain patients at a reasonable level of health. They function always waiting for the other shoe to drop, knowing that something else is going to pop up along the line.

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AIDS and the Law

By Saul J. Morse, J.D. and N. Lee Beneze, J.D./Springfield

The AIDS epidemic raises a host of legal questions attendant to the delicate balance between individual rights and public health concerns. The discussion below considers some of the more urgent public policy issues from a legal perspective and provides some sense of the legislative and social challenge they present.

AIDS (Acquired Immunodeficiency Syndrome) has become not only the major public health problem facing the United States in the 1980s, but the cause of the most intense conflict between public health and individual rights that this country has ever experienced.

The AIDS problem has created a confused conflict between civil rights, legitimate public health concerns, and irrational fear and intolerance, partly because it is still largely believed to be limited to the gay community. For some time the disease was believed to be inherently linked to homosexual activity, particularly promiscuous homosexual activity.[1] It quickly became clear that the threat was not limited to the gay community, but even now about 75% of all diagnosed AIDS patients are gay men. Another 17% contracted the virus through the use of contaminated needles. Only about 2% of patients (and a declining proportion) contracted the disease through the transfusion of blood products.[2]

The second reason that the AIDS problem presents such a challenge to the creation of a rational public health policy, balanced with the protection of individual rights, is that the disease is, in actuality, a death sentence. The mortality rate of AIDS patients within two years after the onset of the disease is 90%.[3] No individual who has contracted the disease has been known to recover.[4]

The final factor in this social and legal quagmire is what is not yet known about AIDS: its origins, precise methods of transmission, incubation period, and even how widespread the problem really is. Some reports indicate that perhaps as many as one million individuals have been exposed to the AIDS virus, but do not themselves have the disease (and may never have it), yet are unknowingly infectious carriers.[5] Perhaps five to ten times the number of known AIDS patients are or will suffer from ARC ("AIDS-Related Complex") a milder form of immune system depression (as opposed to AIDS' virtually total destruction of the immune system) that will leave these individuals vulnerable to various opportunistic infections.[6] The general public, cognizant that there is a problem, assaulted by sensationalist media coverage, concerned about the apparently inevitable fatal conclusion of the disease, is in need of straightforward information.

The AIDS patient—already confronted with a debilitating disease and eventual death—is additionally burdened with what amounts to a rejection by society. Employers may seek to discharge him, public schools (if he is a child) may seek to bar him from the classroom, landlords and neighbors may try to force him to move, and insurance companies may try to avoid coverage.

The other side of the argument over protecting the legal and civil rights of the AIDS patient from discriminatory treatment in housing, education, and employment is the growing (sometimes sound, too often panicky and irrational) concern for public health. The difficulty for the general public—not to mention legislators, government officials, and educational administrators—lies in sorting out legitimate public health concerns from the totality of the AIDS scare. Those concerns must be fitted into a legal system that has grown quite sophisticated in barring discrimination as to race, sex, religion and physical disability, but now has to cope with a contagious, fatal, and socially stigmatized disease.

The AIDS problem, while first noted in Los Angeles and New York, is now an Illinois problem. As of April 1987, Illinois had a reported 903 cases (661 in Chicago). Of this number, 522 patients had already died from the condition. Based on the ratio of known cases

to persons believed infected with the virus, there may be 40,000 infected Illinoisans.[7] Of these, there are 13 children reported with AIDS, though it is likely that the actual number of children may be much higher.[8] Of all the victims of both the AIDS disease and the social stigma which accompanies it, perhaps none are more tragic than children. Of all the "rights in conflict" situations caused by AIDS, perhaps none are more bitterly contested than those involving a young AIDS patient and school attendance. While Illinois has not had a case of publicized conflict on this issue, other states have.

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The public has become aware of (if not totally sympathetic to) the plight of children who have been barred from elementary schools because they are AIDS patients. Nationally, about 500 children under the age of 13 have been diagnosed as having AIDS. By 1991, the Surgeon General estimates that number will be 3,000.[9]

While in some cases the courts have protected the rights of young students to attend school, the outcome has not always been happy. Ryan White, then a 14-year-old AIDS patient, attempted to return to school in Kokomo, Indiana, in April, 1986, after a state court judge dissolved a preliminary injunction that barred him from public schools. Some parents removed their children from the public school and attempted to start their own school.[10] The concern of parents was that, given the physical contacts and sharing of objects between children, the risk of exposure to some of Ryan White's body fluids—and the possibility of transmittal of the AIDS virus—was simply too high. The inability of the public to accept some degree of medical uncertainty as to the exact probabilities of transmission, coupled with the horrendous result if that medical judgment were wrong, created the conflict between Ryan's rights and those of other students. The educational administrator, much like the employer of a diagnosed AIDS carrier, must also be concerned with the institution's liability should a fellow student or worker, after having some demonstrable degree of contact with a known AIDS carrier, contract AIDS. The potential for liability to the employer or school system could be enormous.[11]

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The Centers for Disease Control (CDC), in guidelines for use by educational administrators and employers, states that the virus cannot be spread by casual contact, and thus, there is no legitimate medical reason to exclude children from school, or discharge affected employees from their jobs, if they are otherwise able to function.[12] A recent decision by the Supreme Court may translate this medical judgment into a legal basis for the protection of AIDS patients in the workplace—when federal funds are involved.

On March 3, 1987, the United States Supreme Court made a decision as to the coverage of the Rehabilitation Act of 1973, in a case involving a Florida teacher with tuberculosis. This case may have a significant impact on employment discrimination against AIDS victims.[13] In the *Arline* case, the Court held that a person with the contagious disease of tuberculosis was a "handicapped individual" within the meaning of the Rehabilitation Act, and thus entitled to protection from discharge solely on the basis of having recurring contagious tuberculosis.

The individual in question was an elementary school teacher who had been hospitalized for tuberculosis in 1957. After the disease had been in remission for 20 years, the teacher had relapses in 1977-1979. In 1979, after a third relapse, the teacher was discharged by the school board. The county superintendent of schools testified that the teacher was discharged on the basis of the recurrence of the disease, not on other grounds. The issue at trial, given her medical condition, was whether the teacher was a handicapped person for purposes of the protection of the Act. The trial court ruled that the contagious nature of the teacher's disease meant that she was not protected by the Act.[14] The Court of Appeals

reversed the ruling of the trial court and held that the teacher's medical condition (contagious or not) was within the protective framework of the Act, and thus the question became whether or not she was "otherwise qualified" for the teaching position. The Supreme Court affirmed the ruling of the Court of Appeals.[15]

The Supreme Court reasoned that the Act was meant to protect those persons with some physical or mental impairment due to a medical condition, who are otherwise qualified for the job. The Court ruled that it would be unfair to allow an employer to discriminate against an impaired person because of the effect of that person's condition on others, as distinguished from the effect of the condition on the individual himself.[16] The underlying disease or condition (in this case, TB) is the issue. The Court noted that because *some* contagious diseases pose a health threat to others, this does not permit the exclusion from the Act's protection of *all* those persons "with actual or perceived contagious diseases."[17] The next step would be to determine whether the person would be "otherwise qualified" for the position which they hold (or seek to hold). In this case, the Court sent the case back to the District Court for a determination, based on medical knowledge and judgments, of the nature of the risk—determining in what ways and how much of a threat to other persons the situation presented.

The purpose of this case-by-case inquiry is to balance the goal of protecting the handicapped individual from stereotypes, prejudice and unfounded fear, while at the same time "giving appropriate weight" to protecting others from significant health risks. If the employer can make reasonable accommodations to retain the employee in an alternate capacity (in which they are qualified), while protecting others from the actual health threat posed by the individual, they are obligated to do so.[18] The bottom line of the *Arline* case is that a person suffering from a contagious disease is protected by the Rehabilitation Act, and any limitation or termination of employment of an otherwise qualified employee with a contagious disease *must* be based on reasonable medical judgments as to the health threat posed to others, after making reasonable efforts to accommodate those.

The bottom line of the* Arline *case is that a person suffering from a contagious disease is protected by the Rehabilitation Act, and any limitation or termination of employment of an otherwise qualified employee with a contagious disease must be based on reasonable medical judgments as to the health threat posed to others, after making reasonable efforts to accommodate those.

The Court was aware that the *Arline* case would be interpreted as a statement of the law likewise applicable to AIDS patients. The Court did note (in reponse to an argument from the U.S. Department of Justice) that the case did not reach the question of whether an AIDS carrier (without the symptoms of the disease) would be considered a handicapped person protected by the Act.[19] However, the core reasoning of the opinion would seem to apply with equal force to a diagnosed AIDS patient as to a TB patient.

The protections of the Act would then apply to an employee with AIDS, with the same required balance between health concerns and reasonable accommodation in the job. The *outcome* of this weighing and balancing test may be unique in the case of an AIDS-afflicted employee, because of the dangers of the disease and the relatively larger areas of medical uncertainty. Nevertheless, the *Arline* case clearly indicates that an AIDS patient, even though contagious, is protected under the Rehabilitation Act from discrimination based purely on the fact that the employee has an active case of AIDS.

Illinois Rulings

The Illinois Department of Human Rights has announced that AIDS is a handicap under the Human Rights Act.[20] "Discrimination against a person who has AIDS is prohibited by the Act if the condition is unrelated to ability to perform a given job, acquire or maintain a housing unit, repay a loan, or use a place of public accommodation".[21] At the time of this writing, the Human Rights Commission had before it two cases of AIDS discrimination, but no decisions had yet been rendered. Like the future cases which will result when federal courts attempt to apply the analysis called for in the *Arline* case decided by the Supreme Court, the Human Rights Commission, and eventually the Illinois courts, will have to take some extremely tough cases.

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Many of these cases will arise in conjunction with the relationship between the effects of the disease and the patient's ability to perform a particular job. As in the *Arline* case, the very contagiousness and deadliness of the disease impacts on certain jobs, *e.g.*, teachers, nurses, food services people. Likewise, the free use of public accommodations may not be possible because of the effects of the disease on the patient and on others—but under what conditions is this related to using a place of public accommodation? Such questions may keep the Commission and courts—particularly with the growth in the number of AIDS patients—busy for a number of years.

As in many other states, the Illinois General Assembly has rushed toward a legislative response to the problem. At least 57 pieces of legislation were introduced in the General Assembly in the spring of 1987.

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The scope of the proposed legislation is quite broad. One bill would create an AIDS Advisory Council (made up of 25 members, both public and private, medical and non-medical); an AIDS Control Unit in the Department of Public Health; and make the identity of the subject and the results of a test for AIDS exposure confidential, unless the subject of the test consents or under certain other situations.[23]

Another bill would require the test for the AIDS virus be given to all prisoners upon entering into the custody of the Department of Corrections. If the prisoner tests positive, the correctional facility would take steps to prevent the transmittal of the virus to other persons.[24] While it is not spelled out what steps this would entail, it would imply the existence of an "AIDS ward." There is a serious danger of AIDS spreading throughout prisons—an environment with both voluntary and involuntary homosexual activity, and where many inmates were exposed to both "dirty needles" and contact with prostitutes (who are possible carriers) prior to incarceration.

Another piece of legislation would require the AIDS patient to identify past sexual contacts, and the Department of Public Health to follow up on those contacts by notifying them of their vulnerability to the disease and encourage testing.[25]

As might be expected of a disease that strikes mostly high-risk (and socially unpopular) groups, some insurance firms are declining to write health policies for identifiable higher-risk persons. Reportedly, some major insurance companies are requiring some persons to submit to the HTLV-III antibodies test (the ELISA test) prior to extending coverage.[26] In response, California has prohibited the exclusion of AIDS coverage in group plans when coverage for alcohol-related diseases and lung cancer are not excluded.[27] Given that the cost of treating one AIDS patient may range from $60,000-$140,000, the concerns of an insurance company are understandable.[28] With the possibility of the drug AZT (which itself will cost thousands of dollars a year per patient) extending the life-span of an AIDS patient, the costs of medical care for AIDS patients would continue to climb astronomically.

The appropriateness of the use of the ELISA test for mass screening purposes, particularly in light of the possible harm that could befall a person who tested positive, has been recently questioned.[29] One problem concerns the individual who tests "positive" on the ELISA test, but is not in fact affected by the HTLV-III virus. The ELISA test does not test for the HTLV-III virus directly, but tests for the presence of antibodies to the virus. In 0.2% of all tests, the results will be a "false positive"—indicating that the individual has had HTLV-III exposure, when that is not the case. The problem arises when this admittedly very low rate of erroneous results takes place in testing a low-risk group of the population. If the total positive rate is 0.3%, and the "false positive" rate is 0.2%, then 2 out of 3 persons who tested positive will in fact not have been exposed. Thus, of 300 persons who have a test result of "positive" in a low-risk group of 100,000, approximately 200, or two-thirds, will be "false positives."[30] Of the number who have been actually tested for the presence of HTLV-III virus and found infected, approximately 50% will not develop any AIDS symptoms, 20%-30% will develop AIDS-related complex (ARC) symptoms, and 5%-20% will develop a full-blown, and ultimately fatal, case of AIDS.[31] Mass testing has included 3 million in the military, 8,000 Foreign Service personnel, and 60,000 applicants to the Job Corps Program.[32]

The significance of these figures lies in the need to maintain, to the highest degree possible, the confidentiality of test results. An individual who tests positive in the ELISA test will not necessarily develop a case of AIDS.[33] The misuse of a positive test result which could severely damage an individual must become a major concern of any legislative action on the subject—and the medical community's response to that legislation.

Government Responses

The state government has already started to take some response to the AIDS crisis. Effective in June, 1986, the Illinois Department of Public Health adopted rules for

dealing with the problem of blood banks and the AIDS virus.[34] The IDPH amendments provided that blood samples from donors be tested and, if the results are positive, rejected. If a confirming "Western Blot" test produces a positive result, the donor's physician or the donor will be informed of the results. Prior to this rule, the blood bank could not release the test results.

IDPH also amended their rules relating to "Control of Communicable Diseases."[35] These rules provide that every known and suspected case of AIDS be reported to the local health authorities. AIDS patients would then be handled with appropriate infection control techniques.

An AIDS patient in a hospital, nursing home or other health facility is to be subjected to isolation procedures as spelled out by CDC guidelines. All equipment contaminated by the patient's blood or bodily secretions must be disinfected. AIDS patients are prohibited from donating blood, sperm or body organs (with certain exceptions).[36] The remains of a deceased AIDS patient must be labelled "Infectious Hazard" to notify the funeral director to take appropriate precautions during embalming. If death occurs in a private residence, this responsibility lies with the attending physician. If death occurs in a health care facility, the administrator of the facility is responsible for making sure this is done.

The General Assembly has empowered the Department of Public Health to conduct a public information campaign, establish a statewide hotline and take other measures necessary to increase understanding among members of the general public and the medical community.[37]

The General Assembly also directed hospitals to develop protocols (subject to Department of Public Health approval) for notification of paramedical and ambulance personnel about to render medical services to patients with "dangerous, communicable or infectious diseases" (including AIDS). This notification does not include the name of the patient, which is treated as confidential.[38]

It has been estimated that the total cost of the AIDS disease from 1981 to 1985 was $6 billion. That includes $1.4 billion in medical care and $4.6 billion in the lost wages of AIDS patients.

It has been estimated that the total cost of the AIDS disease from 1981 to 1985 was $6 billion. That includes $1.4 billion in medical care and $4.6 billion in the lost wages of AIDS patients.[39] Additionally, in Fiscal Year 1987, the federal government will spend $79.5 million on AIDS public education.[40] Millions of dollars have been and will be spent on research, public education, and public health-disease control administration; billions more will be spent on medical care. It is estimated that by the end of 1991, 179,000 persons will have died of AIDS (of 270,000 diagnosed cases).[41]

Summary

The continuing debate between advocates of differing perspectives of public health, privacy, and civil rights means that public fear can only grow more intense as the number of AIDS patients expands. Within the Congress, each state legislature, and every state and local public health department, the debate continues. Soon state legislatures will have to pass laws addressing the rights of AIDS patients in the context of patient privacy and public health concerns. Eventually state supreme courts and the United States Supreme Court will have to decide the cases that (unlike *Arline*) directly address the employment, educational, privacy and housing rights of AIDS patients. Until that time, the law, like the public and political debate, will be confused, changing and inconclusive. ◀

References

A complete list of references for "Aids and the Law," may be obtained by writing the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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Overview and Historical Perspective

Surgeon General Speaks Out on AIDS

By C. Everett Koop, M.D., Sc.D.

The U.S. Surgeon General, C. Everett Koop, M.D., Sc.D., recently presented a talk at the Children's Hospital of Philadelphia titled, "The Current Crisis in AIDS." The material below is excerpted from that presentation, which covered clinical and social issues attendant to the epidemic. As surgeon general of the U.S. Public Health Service and deputy assistant secretary of health for the U.S. Department of Health and Human Services, Dr. Koop provides a unique perspective on the subject.

In June of 1981, the U.S. Public Health Service published the first reports of five cases of *Pneumocystis carinii* pneumonia in Los Angeles.

Five cases may not sound like too many, but this lethal disease is so rare that a handful of cases in a single year is like an epidemic.

Soon, similar reports began to trickle in from other cities. A month later, the editor of the *Morbidity and Mortality Weekly Report* (*MMWR*) published a report that 26 young men had been recently diagnosed with Kaposi's sarcoma, a rare malignancy usually restricted to elderly men.

The *MMWR* editor noted in the July 1981 issue that these 26 young men, like those first five in Los Angeles with pneumocystosis, were young homosexuals. And in that same issue, the editor published 10 new reports of pneumocystosis, all of them involving young homosexuals.



C. Everett Koop, M.D., Sc.D., U.S. Surgeon General

Public health investigators then reported that people were not only sick with these very dangerous diseases, they were dying of them. For some mysterious reason, their bodies were not fighting back.

Apparently these victims had acquired some kind of "bug"—a virus, most likely—that attacked and destroyed their natural immune systems.

Medicine had never come upon a syndrome quite like it before. We gave it a long title: the "acquired immune deficiency syndrome." But we soon settled just for the initials: A.I.D.S. . . . or "AIDS." And it's been AIDS ever since.

The Task for Public Health

Four key points are essential to any discussion of AIDS.

First, we're talking about a disease that is *spreading* and is *fatal.* It now takes about a year for the number of victims to double. At the end of 1985, we had a cumulative total of about 19,000 reported cases. Today the total number of AIDS victims is just shy of 34,000. Over half of them have already died

of the disease, and the rest probably will. This year we expect to add another 23,000. By the end of 1990 the cumulative total will be over a quarter of a million.

Identification and Definition

The *second* point is this: even though scientists have had a look at the AIDS virus, we still don't know precisely what it is.

In 1984 the search was narrowed down to a human retrovirus. Scientists at the National Cancer Institute identified a specific one, the "human T-cell lymphotropic virus type III," or simply "HTLV-III."

The same virus showed up in the work of the Pasteur Institute, where it became known as the "lymphadenopathy-associated virus," or "LAV." Scientists now agree to call it by the single common name of "human immunodeficiency virus," or "H.I.V."

Even though scientists have had a look at the AIDS virus, we still don't know precisely what it is.

At the end of 1985, we had a cumulative total of about 19,000 reported cases. . . . By the end of 1990 the cumulative total will be over a quarter of a million.

The ability to recognize the virus was a very important development. Once you know where the AIDS virus is, you can recognize the presence of antibodies specific to it.

Of course, those antibodies aren't very effective, but they're present nevertheless.

In 1985, a test that detected the presence of these antibodies in a person's bloodstream became available. Before the test was developed, the AIDS antibodies were turning up in about four or five units of blood per 10,000 units. Now, since blood screening was begun, that figure has come down to about four units per one million units of transfused blood.

On the basis of such testing, plus other epidemiological data, we believe there are between a million and a million-and-a-half Americans walking around with the AIDS virus in their systems. They have AIDS, but they aren't yet sick with an AIDS-related disease, such as *Pneumocystis carinii* pneumonia or Kaposi's sarcoma or any of the virulent megaloviral diseases.

The incubation period is a major problem in any projections. It changes. Apparently, it can be anywhere from a year or so in some people to 10 years in others. We can't predict which person carrying the AIDS virus will or will not get an AIDS-related disease.

But it's not a 50-50 risk. The possibility of infectious disease is still very, very high. In fact, some researchers now feel that *anyone* with the AIDS virus will eventually contract an AIDS-related disease and die.

Research also continues in the area of drug therapy and vaccine development. In fact, research now commands about $300 million in federal funds this year, plus many millions more in state and private sector funds.

One new experimental drug, Azidothymidine, or A.Z.T., has gone through a so-called "fast-track" approval process and is now being used to prolong the lives of AIDS victims dying of *Pneumocystis carinii* pneumonia. But I'm afraid that's all AZT does. It *prolongs* some lives; it does not save them. For saving lives, we need a vaccine.

People want to know when an effective vaccine might be available. And I have to tell them that I don't see one in the near future. We're moving ahead on this front as quickly as we can. But vaccine development is one thing that cannot be rushed without creating more problems than we already have. We need to remember that it took 19 years to develop the hepatitis B vaccine, and that was a comparatively easy virus to understand.

Mode of Transmission

The *third* key point is as important as the first two: We don't know very much about AIDS, but we *do* know—with complete certainty—that the virus is transmitted from one person to another, either in blood or in semen.

This is one of the most important pieces of information we have so far. It explains, for example, why the initial alarm about AIDS was sounded among homosexual and bisexual men. Some sex practices among these men not only produce semen but may also cause some bleeding. Again, blood and semen are the only two body fluids we know to be sufficiently concentrated to carry and transmit the live AIDS virus (at least until we learn more about the virus in cervical secretions).

Other less concentrated body fluids—saliva, tears or perspiration, for example—don't carry the virus and there are no substantiated cases to the contrary.

The biophysical peculiarities of the AIDS virus also explain why 17% of all AIDS cases are intravenous drug abusers who use contaminated needles and other paraphernalia they've borrowed from other addicts who have AIDS.

When we first began to confront the AIDS epidemic, the people at highest risk were homosexual and bisexual men and I.V. drug abusers, male and female. I'm afraid they still are: nine of every ten cases

involve these kinds of individuals.

But more recently, we're receiving reports of the AIDS virus occurring among *heterosexual* men and women who are *not* I.V. drug abusers. In fact, their heterosexual activity seems to be their *only* risk factor.

As of last week, four percent of all reported AIDS cases were of such heterosexual men and women . . . a percentage, by the way, that's climbing.

Another concern is the rise in AIDS among blacks and Hispanics. Blacks account for 12% of the population, but they account for 25% of all AIDS cases. Similarly, Hispanics account for six percent of the U.S. population, but they account for 14% of all AIDS cases.

The demography of this disease is becoming as complex as the disease itself.

Education: The Sole Defense

This leads to my *fourth* point: our single defense against this disease from the very beginning has been information and education. And it still is.

Over the past five years, we've beamed information almost exclusively to homosexual and bisexual men and, wherever possible, to drug abusers. Among homosexuals, this campaign seems to have been effective; their sexual behavior has apparently changed. I am advised by their leadership that there's been a noticeably sharp drop in the numbers of men taking part in wholesale, anonymous, promiscuous sex.

As a result, a decline is already occurring in the incidence of other sexually transmitted diseases among homosexual men, such as gonorrhea, hepatitis B, and syphilis.

We now need to direct our information and education efforts to heterosexual men and women, which is to say, to society at large.

That's very hard to do in this country. We're very large and very diverse. So we've had to set some priorities and make some tough choices. But I think we made the right choice when we decided to focus on telling young people the facts about the threat of AIDS.

What we're doing, then, is focusing on those pieces of information that are especially pertinent to—and can be readily understood by—young people.

That was the underlying plan for the *Surgeon General's Report on AIDS,* which I released last October. Early in February 1986, President Reagan instructed me to pull together everything we knew about AIDS and put it into a plain-english report to the American people.

I met with concerned individuals and groups from across the spectrum of society. After eight months of listening and writing, I delivered my report to the Cabinet and to the President. It was accepted, and I released it to the American people on October 22, 1986.

I want to assure you that at no time have I had any misgivings about anything I wrote. Copies are available by writing AIDS, Post Office Box 14252, Washington, D.C. 20044.

The best defense against AIDS is to maintain a faithful, monogamous relationship in which you have only one continuing sexual partner, and that person is as faithful as you are.

We don't know very much about AIDS, but we do know—with complete certainty—that the virus is transmitted from one person to another either in blood or in semen.

There is much scientific and public health information in that report, but on the behavioral side, there are essentially just two messages and I hope they reach every one of this country's youngsters.

The first message is simple enough: Find someone who is worthy of your respect and your love, give that person both, and stay faithful to him or her.

In other words, short of total abstinence, the best defense against AIDS is to maintain a faithful, monogamous relationship in which you have only one continuing sexual partner, and that person is as faithful as you are.

My second message is for people who don't yet have a faithful monogamous relationship for whatever reason. Unless you know with absolute certainty that neither you nor your partner is carrying the AIDS virus, you must use caution.

Remember, from the viewpoint of epidemiology, when you have sex with someone, you're also having sex with everyone else with whom that person has had sex.

And, when you consider the long incubation period for the AIDS virus, we're talking about that person's history of sexual relations going back five years or perhaps longer.

If you *do* decide to have sex with someone and you are not absolutely certain about his or her sexual history, then, if you're a man, use a

condom from start to finish. If you're a woman, make sure your male partner uses a condom, again, from start to finish.

A condom won't provide 100% protection—few things in life do—but so far it seems to be the best protection available.

The Educational Process

How should we educate our young people about AIDS and about their sexuality? Who should do it? And when?

I believe that education is a local matter, that parents and the community control what goes into their schools, and that the system has worked very well for us for over 200 years. I have absolutely no desire to quarrel with or change it.

I also believe that the federal government should continue to play a strong supporting role in providing timely, factual, and impartial information to the schools for them to use. I tried to do that in the *Surgeon General's Report on AIDS* and I think I was successful.

And when I offer advice, which has always been a major aspect of the surgeon general's job, it is just that: *advice.*

In addition to the facts about the disease of AIDS, I've been adding my advice that one of the best things our society might do to protect its young people from this mortal threat is to educate them about human reproductive biology and their own sexuality, and do it in a way that is factually correct and personally sensitive.

Most schools now offer some minimum kind of sex education during the junior high or middle school years and that's a good thing, although it might be a little late. I personally would urge that the material be presented earlier, among the 9-, 10-, and 11-year-olds. Of course, developmental age is more important than chronological age.

My own preference, also, would be to have children introduced to the subject of reproductive biology within a more general discussion of the nature of sensitive and affirmative human relations.

There's more to male-female relationships than just "good sex." And young people ought to understand that. We may not always achieve the ideal relationship, but the ideal should be at least understood by young people as being a reasonably good yardstick.

Male-female relationships ought to be equitable, respectful, loving, and caring. That's the ideal that children should know about. And they should also know that most people settle for less and that's what is commonly known as "the human condition." There's nothing wrong with that idea either.

These are important concepts concerning human relationships and sexuality, and I happen to think that parents ought to be the ones to teach them.

The difficulty, of course, is that if parents are to educate their children about human relationships—sexual and otherwise—they must first understand and accept the nature of their own. And for many, that's hard to do.

Parents—and adults in general—are not very good about talking to each other about their sexuality. They feel frustrated, guilty, and even angry about their inability to handle this topic. This is clearly a major reason why such third parties as "Dear Abby" and "Dr. Ruth" are so popular. They do all the difficult verbalizing for us.

One of the best things our society might do to protect its young people from this mortal threat is to educate them about human reproductive biology and their own sexuality, and do it in a way that is factually correct and personally sensitive.

It's difficult for parents . . . but I want parents to try. I want parents to talk about this with compassion, with respect, with love, and with some understanding not only of the child who's *listening* but also of the adult who is *speaking.*

But when parents can't get the job done, then I believe there's a compelling social need for our schools, churches, synagogues, and other community institutions to do whatever possible to provide our children with the information they need to understand their sexuality and to protect themselves from AIDS.

Our only hope as a nation and as a civilization is that we Americans will do our part to stop the spread of AIDS, that we will protect and save the lives of people at risk, including unsuspecting young people, and that we will return human sexuality back to its rightful place, as part of the total complex of human, caring, interpersonal relations. ◀

The Acquired Immunodeficiency Syndrome

Issues for Hospital and Medical Staffs

By Agnes D. Lattimer, M.D./Chicago

As medical director at Cook County Hospital, Dr. Agnes Lattimer has experienced the extraordinary public furor resulting from a medical staff decision to limit the privileges of a physician with AIDS. We asked her to offer insights into the particular problems attendant to medical and hospital staff members diagnosed with AIDS or testing positive for AIDS antibodies.

In 1981, the Acquired Immunodeficiency Syndrome (AIDS) was identified in the United States.[1,2] From June 1981 to December 1986, over 28,000 persons in the United States were reported as having AIDS.[3] It is estimated that by the end of the year 1991, we will see a cumulative total of over 270,000 cases. More than 74,000 of these are expected to occur in 1991 alone and the fatality rate is expected to approach 100%.[4]

The picture of AIDS has evolved from isolated cases of opportunistic infection in young homosexual men with no history of disease predisposing them to immunologic deficiency, to awareness of a new syndrome. Identification of causative agents and delineation of risk factors have led to a better, albeit incomplete, understanding of the course and prognosis. Many changes in concept about the AIDS problem have occurred over the past six years, with new information and manifestations.

The predominant risk groups continue to be homosexual males and intravenous drug abusers, although the exposed groups have expanded significantly.[5,6] In addition, modes of transmission previously considered unlikely have occurred, including heterosexual, horizontal and non-perinatally acquired vertical transmissions.[7-10]

In accord with these developments, the general public has become quite knowledgeable about the AIDS problem.[11] Press coverage has identified AIDS as the scourge of this century, even likening it to the Bubonic plague. As a result, this level of knowledge is accompanied by an intense level of anxiety about the vulnerability of the community to AIDS and the risk of transmission.[12-14].

It has been documented that the AIDS virus (HTLV-III/LAV) can be isolated from bone marrow, semen, saliva, tears, breast milk, vaginal secretions, blood, and feces.[15-17] Despite presence of the AIDS virus in body fluids, casual contact with an infected person, whether symptomatic or asymptomatic, has not been found to transmit HTLV-III/LAV. However, there has been an instance of transmission between an infected infant and mother.[18]

Extraordinary Public Policy Implications

The full implications of the AIDS epidemic are only dimly understood, but the projection of extremely large numbers of patients with long asymptomatic intervals between acquisition and clinical presentation causes great concern.[19] This presumes a very large reservoir of people capable of transmitting the infection and has serious and ominous implications for the future, both in terms of the availability of care and the cost of care and research.

As a result of advances in medical technology, vaccines and antimicrobial agents, recent history has seen acute infectious disease take a back seat to chronic disease. Steep rises in medical care costs have fueled stringent cost cutting strategies. The simultaneous growth of the concept of individual responsibility for personal health has brought new emphasis on self-initiated "lifestyle" changes.[20] Scientists and physicians have lost status and credibil-

ity.[21,22]

Hospital administrators and medical staffs have to face unique concerns as they examine the issue of compliance with the Centers for Disease Control (CDC) guidelines for health care workers with AIDS.[24,25] The first is the "crisis of confidence" concerning credibility of information about AIDS.[26] There is conflict among experts about the focus of educational efforts,[27] relative value of testing,[28] natural history of the infection,[29] factors which enhance likelihood of acquisition of the AIDS virus from the multiple sources,[30] progression to AIDS from positive antibody status,[31] reliability of antibody tests for HTLV-III/LAV,[32] accuracy of reporting about AIDS (particularly pediatric AIDS),[33] changing guidelines for diagnosis and reporting of AIDS,[34] and prevalence and significance of antibodies to AIDS in heterosexual populations.[35,36]

The second issue which hospital and medical staffs must address is the controversy about transmission of AIDS. Initially, primary victims of the disease were gay men and intravenous drug abusers. Because of the population affected, unique socio-political factors came into play. While the percentage of cases with no identified risk factors has remained constant, the number is increasing.[23]

In addition to controversy between community people and the "experts" there is a third factor: lack of confidence in the decision-making process which underlies policy decisions that have public implications. When a public policy decision is made about so serious a disease as AIDS, representatives from the groups who are going to be affected must have input.[37] This underscores the differences in response patterns of public and private hospitals to the issue of employees, especially physicians, with AIDS.

Public vs. Private Institutions

Private and public medical institutions have had different roles throughout the evolution of the AIDS epidemic. Public and private hospital staffs can be expected to have different attitudes toward delivery of care to patients who have AIDS and employees who are discovered to have AIDS.

Many private hospitals do provide comprehensive medical care to patients with AIDS as well as the necessary education for hospital personnel. But they have a different role in relation to their patients than does a public institution. At a public institution like Cook County Hospital, which is the sole source of care for thousands of patients, the community perception of safety has different implications. At a hospital like County, patients get a health care worker who is on call. They have no choice about selecting or continuing with that physician. In a private institution—even though they may get the physician on call—they have a choice because of the ability to pay. The patient may elect not to continue with that health care provider. Therefore, the implications of community perception of the relative safety of the hospital is somewhat different between private and public hospitals.

A Delicate Balance

The fourth area that creates issues and conflicts for hospital and medical staffs is the need to strike a balance between individual rights to privacy, autonomy, and independent action, and responsibility to their constituencies. Hospitals have a primary responsibility to provide a safe environment for their patients and employees. That is paramount. They also must maintain confidentiality of medical records and test results.[38] They must use the least restrictive alternative if they must curtail the privileges or activities of employees with AIDS.[39] This "least restrictive alternative" has to be strictly applied, but can include transferring employees from departments where they will not have contact with patients' body fluids.[40]

Hospital and medical staffs also must lead and participate in AIDS prevention education and clarify issues about the safety of the health care setting. This commitment to participate must include an educational focus with their own employees at all levels. It must simultaneously involve the community, utilizing groups and settings which are natural, such as churches, health centers and block clubs. The hospital and medical staffs also must decide how best to focus the education and whether or not to combine it with a screening program for high risk groups, employees, hospital admissions, prenatal patients, etc.

Monitoring Criteria

Compelling issues face the medical staff as they consider how to handle the health care worker with AIDS: How will they monitor the health care worker for compliance with CDC guidelines? What clinical features of the health care worker must be monitored? How often should they be monitored and by whom? How is the confidentiality maintained in the monitoring process?

While it is assumed that the health care worker will be capable of self-monitoring and will have both the integrity and the commitment to self-monitor, this may not be possible because of the variability of the clinical picture of AIDS, particularly the very early advent of central nervous system symptoms.[41] Hospital and medical staffs have monitoring responsibilities and must set criteria for that process. They have attendant potential liability, because a health care worker known to have AIDS must be monitored to minimize the likelihood of transmission to patients or other staff. Hospital and medical staffs can acquire liability if they do not demonstrate that they are monitoring for compliance with these guidelines.

There is a simultaneous responsibility to minimize the exposure of the health care worker because the health care environment offers an enhanced likelihood of exposure to infectious disease and the health care worker with AIDS has an impaired immunologic system.

Confidentiality and Public Health

Hospital and medical staff responsibility to strike a balance between individual rights and public health protection is highly complicated. Staffs must identify criteria for situations in which public policy will be permitted to infringe on the rights of autonomy, liberty and privacy of individuals. In this context, the major controversies surround the extent to which public policies of

quarantine, infringement and mandatory testing are to be utilized with AIDS. Loss of confidentiality in an AIDS diagnosis or an AIDS positive test carries ramifications in the areas of housing, employment, insurance and health benefits.

The final issue for medical staff and hospitals relates to the patient's "right to know" if a health care worker with AIDS is to perform invasive procedures. For health care workers who are not performing invasive procedures, the risks of transmission of the AIDS virus are very minimal and compliance with the CDC guidelines should certainly be effective. However, a physician who cuts himself with the scalpel or knife in the course of an invasive procedure risks mixing his blood with that of the patient. The CDC guidelines state that, in this instance, the health care worker must tell the patient that he has been exposed and what the standard protocols are. I would raise a question in this regard. In this day of informed consent, patients have a right to know when a health care worker who is about to do an invasive procedure has a potentially communicable disease. They don't have to say whether it's AIDS or hepatitis B, but I think this is an issue that has to be resolved.

Summary

Hospital and medical staffs have many issues to deal with as they approach the question of health care workers with AIDS. The fundamental issues are protection of employee rights, understanding of personnel attitudes and behavior, modifying these when necessary and leading the fight to prevent the transmission of the AIDS virus, which is the main personal tragedy. The decision making process which hospital and medical staffs employ will come under constant scrutiny. They will have to develop guidelines, which they continuously review and amend, in terms of outcome and perception, based on their experiences and those of similar institutions.

The AIDS epidemic has created many new problems, which must be solved by a combination of consistency, high professional standards and a commitment to restore public confidence to the medical and scientific community. ◂

References

A complete list of references for "The Acquired Immunodeficiency Syndrome (AIDS)" may be obtained by writing the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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Aids Education for the General Public

The American Medical Association has issued a series of monographs providing guidelines for persons confronting the AIDS problem. Summarized below are highlights of recommended physician comments for patient education.

- The HIV virus is transmitted by sexual relations, the transfusion of blood, the sharing of needles contaminated with blood, or perinatal exposure. There is no evidence that other person-to-person interaction among workers, consumers, clients, or school children poses a risk for transmission of HIV.
- Persons with AIDS or the HIV infection should not be restricted from work, school, or personal interactions. Telephones, office and school equipment, toilets, showers, eating facilities, and water fountains can be used safely.
- Sexual relations with persons at increased risk for the HIV infection can result in HIV transmission. The risk increases with the increasing number of sexual partners. The use of condoms may reduce the risk of HIV transmission.
- The use of intravenous drugs and the sharing of needles and syringes can result in HIV infection.
- Persons at risk for HIV infection should not donate blood, semen, or organs.
- Women of child-bearing age who are at risk for HIV infection should determine their HIV antibody status before conception or defer pregnancy by use of barrier contraception. ◂

AMA Advocates Criteria for Selective HIV Antibody Testing

By James H. Sammons, M.D., President

The American Medical Association believes that all physicians need to be knowledgeable about AIDS and to accept a continuing responsibility to remain informed of important developments in the area. They have provided this information with that goal in mind.

The Centers for Disease Control (CDC) drafted an article in their publication, *Morbidity and Mortality Weekly Report* (*MMWR*), advising that individuals and the sex partners of individuals who received a blood transfusion or other blood product during the period from 1977 to March, 1985 should seek the counsel of their physicians as to whether they should obtain HIV antibody testing. The article suggests that physicians be selective in advising asymptomatic patients, recommending the tests for those who have the greatest likelihood of having received HIV-contaminated blood, *e.g.*, those who received multiple transfusions in areas with a high incidence of infection, and especially those who have been sexually active since receiving the blood product.

It has been estimated that during the above period more than 30 million people received transfusions with as many as 20,000 persons possibly receiving HIV contaminated blood products. As news articles discussing the *MMWR* article appear in the public press, physicians should expect to receive a number of inquiries from patients who have had blood products given to them. As physicians, we should be prepared to evaluate the potential risk of HIV infection in past recipients, counsel these patients, and take the opportunity to share our knowledge of HIV disease and its transmission. Local and state public health departments should be consulted by physicians, not only for information on HIV disease, but also for location and availability of testing and counseling sites.

Groups of individuals who received blood products during the 1977 to March, 1985 period who should be advised to seek HIV antibody testing include: (1) hemophiliacs; (2) those who have received multiple blood transfusions; (3) those who received blood products collected from donors living in an area with a high incidence of infection; (4) especially those in the first three groups who have been sexually active; (5) sexual partners of individuals at risk; and (6) patients who exhibit substantial anxiety about the possibility of HIV infection.

Physicians will undoubtedly receive inquiries from a number of anxious patients who are at very low risk of having received HIV contaminated blood. They will need to be reassured. The probability of any single patient receiving a unit of contaminated product during the period in question is very low, and decreases as one goes back in time toward 1977. It would be extremely low for persons who received only a few units of blood, were living in an area with a low incidence of AIDS and are currently asymptomatic. Nonetheless, there doubtlessly will be anxious patients who cannot be reassured by these probabilities, and for them HIV antibody testing may be the only satisfactory method of dealing with their fears.

The number of persons who potentially may seek the advice and counsel of physicians is very large. If one includes at least one sexual partner for every one of the 30 million persons estimated to have received a transfusion during the period in question, then the total

would be 60 million persons, reduced somewhat by the number of persons who have died in the interim. It is very likely that only a very small percentage of these people will turn out to have been exposed to HIV seropositive blood. It is imperative that physicians exercise professional judgment in determining which of their patients should seek HIV antibody testing. The capacity of facilities and counseling services for HIV antibody testing is limited and not readily available everywhere. The system could be overwhelmed if we are not judicious in identifying the patients who need to seek such testing.

This latest development in AIDS supports the AMA position of keeping physicians informed of important developments. To this end, the American Medical Association has implemented an AIDS Action Plan that emphasizes physician, as well as public, education about AIDS. Six AMA-sponsored educational workshops on AIDS for physicians have already been held and more are planned. A monograph on AIDS designed for non-specialists has been prepared and shortly will be available. The AMA intends to continue with its educational efforts in response to the challenge that AIDS presents to the world society. ◀

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Public Health Authorities' Challenge

Battling AIDS' Deadly Threat

A large majority of Illinois residents feel that AIDS is very likely to become a general public epidemic. Yet 75% have not taken any precautions to avoid contracting the virus. Less than half of single people say they have reduced the number of their sex partners, and fewer than a third have used a condom. Those who are the least knowledgeable also are the most fearful of AIDS: blacks, Hispanics, Chicago residents, those with low levels of education and income. These findings of a 1987 public survey commissioned by the Illinois Department of Public Health confirm that large gaps exist in public understanding of AIDS. What can be done? What will prove effective in broadening awareness and changing high risk behaviors? IMJ *posed these questions and others to the current director of the Illinois Department of Public Health (IDPH), Bernard J. Turnock, M.D. Under his leadership, IDPH has mounted a major education campaign to reach the general public, physicians and drug abusers.*



IMJ: *Is AIDS really a statewide crisis? Or is it primarily limited to large urban centers like Chicago and St. Louis?*

Dr. Turnock: The case load is presently concentrated in the metropolitan areas. By virtue of its nature and what we can anticipate in the next five to ten years, it would have to be considered a statewide crisis. It's growing at pretty much the same rate in Chicago, suburbs and downstate. Certainly the number of cases downstate is small in comparison to those in Chicago. But the rate of growth is virtually the same throughout the state of Illinois.

The public and doctors should be concerned with the AIDS epidemic, whether downstate or in Chicago. One of the real problems with AIDS is that it's always been seen as "somebody else's" disease: a disease of homosexuals or IV drug users. Many people would like to point the finger somewhere else, arguing that, "it doesn't impact on us—only them." That's clearly not true.

IMJ: *What are your projections on the spread of AIDS over the next several years?*

Dr. Turnock: It's very difficult to predict accurately what is going to happen with AIDS. Over the next few years, we expect to see the same growth rate that we've seen in the last few years—a doubling about every 12 months. Beyond that, it's

very unclear. We hope many of the education and prevention programs will have begun to have an impact. There should be fewer new infections showing up at some future point—two, five or ten years down the road.

IMJ: *Can you project how many of those carrying the virus will actually get the disease?*

Dr. Turnock: We're still evaluating the clinical experience. Each year we find that a larger percent of those infected early in this epidemic develop full blown AIDS. The current wisdom is that at least 30% of those infected will develop AIDS.

The current wisdom is that at least 30% of those infected will develop AIDS. But we don't know whether eventually that number will reach 100% after 10 or 20 years. We haven't had 10 or 20 years' experience with this virus.

But we don't know whether eventually that number will reach 100% after 10 or 20 years. We haven't had 10 or 20 years' experience with this virus.

We simply can't say that someone infected 10 years ago won't develop the disease. A significant length of time is needed to gauge what proportion of those infected will develop AIDS. We won't be clear on this question for many years.

IMJ: *Illinois' General Assembly is looking at several bills to control the spread of AIDS. One is mandatory AIDS testing. What do you think of that concept?*

Dr. Turnock: The epidemic of legislation aimed at controlling AIDS merits careful scrutiny. We must evaluate each and every proposal from a public health viewpoint, to determine which will enhance control of the disease.

Public health professionals generally believe the AIDS test has some benefit. We would like to see it used widely by individuals in assessing their own risk. I think many of us support wider use of the test on a *voluntary* basis. But the problems associated with mandatory testing would actually *decrease* our ability to control the spread of the disease.

Most mandatory testing laws really won't contain its spread. They result in extensive expenditures on very low risk population groups. In order to test all marriage license applicants, we would spend well over a million dollars each year to identify 80 to 100 positive individuals. Most public health officials believe we could identify those 80 with much less expense.

In short, mandatory testing on a low risk population is not cost-effective. It gives a false impression that the disease is being controlled. In fact, testing doesn't help control the disease at all. Testing identifies people who are positive. The purpose of identifying people who are positive is to protect people around them. And you can reach those people—who are around individuals having high risk behaviors—in many other ways. Education programs urging those with AIDS risk factors in their past or current life to present themselves for testing and evaluation is significantly more effective.

IMJ: *How do you feel about quarantines for AIDS patients who continue to threaten others through sexual contact? Is this idea worth consideration?*

Dr. Turnock: No. I don't think quarantine has much of a role in AIDS control. State and local public health agencies already have the authority to deal with individuals who recklessly endanger others by transmitting the virus. What those people need, more than enforced confinement, are supportive services and mental health counseling. They are acting foolishly, irresponsibly and dangerously, and that basic problem must be addressed. Most people who test positive, or who already have AIDS, are incredibly sensitive and responsible about the persons around them. They want to protect them. And certainly not endanger them. The quarantine issue gets much more attention than it should. Consideration of that should be reserved for very unusual circumstances.

IMJ: *If a physician treats an AIDS patient who continues to threaten others, what course of action should he or she take?*

Dr. Turnock: In a number of instances, we've assisted physicians who identify somebody threatening to infect many, many others. We've worked with the physicians; we've pulled in psychologists and psychiatrists; we've alerted local law enforcement officials. We work to find the best arrangement to protect the public, and not infringe upon the personal and civil rights of the individuals involved. Each of these circumstances can be best handled individually.

IMJ: *What can doctors do to educate patients on AIDS? Do you believe they have an obligation to educate their patients? And what's the best method?*

Dr. Turnock: Physicians should realize the important role they can play, especially in light of the way they're perceived by the public and their patients. Our recent public survey showed that well over 90% of the population feel that their doctor is the best person to provide them with information about AIDS. The family doctor scores higher than the health department and even the Surgeon General as a credible source of AIDS information.

Like everyone else in society, doctors must work to overcome their sensitivities about dealing with some of these delicate health questions, and use their potential to bring that message across to patients. They must go out into their communities. Physicians can be effective spokespersons on two fronts: heightening public education on control of the disease and combatting misinformation and hysteria in communities when AIDS first begins to appear.

Physicians underestimate the important role we can play. We're so used to being reactors who wait for patients to come in with problems. Physicians sometimes lose sight of the role we can play in the community to actively and aggressively prevent disease. The public holds physicians in high esteem. Our profession is much more credible than any other source.

IMJ: *Are Illinois communities universally seeking AIDS information and education?*

Dr. Turnock: It varies considerably depending upon where you are in Illinois. Our statewide survey showed that people already know an awful lot about AIDS. AIDS has been widely publicized in the media. But there's been a sensory overload of AIDS information. People have heard so much, seen so much, been exposed to so many different issues and problems relating to AIDS, that they know an incredible amount about it.

Despite how much they know and how much they've heard, the key question is what they're *doing* about it—whether or not they're translating AIDS information into protective or preventive action. We see a large gap between what people know about AIDS and what they're doing in their personal lives to protect themselves. People aren't implementing protective measures where it would appear that they ought to be.

It's much like the smoking issue, although AIDS is certainly much more of an imminent health threat. The stakes are much higher. If you guess wrong, you may die. It's much more of an *immediate* risk and threat to people than smoking, alcohol or drug abuse, not using seat belts, not managing stress, or other behavioral things that we in public health have been dealing with for some time.

IMJ: *What's the biggest public misperception about AIDS?*

Dr. Turnock: The general public too often sees AIDS as a disease of homosexuals or IV drug users. They don't appreciate the risk they have in their own lives. And they don't realize what they ought to be doing to protect themselves. That's the most important finding in our survey. And it really underscores the need for more creative and aggressive education messages and campaigns.

IMJ: *What is the biggest misperception in doctors' minds about AIDS? How can it be corrected?*

Dr. Turnock: Many doctors have feelings about the kinds of groups in which AIDS initially appeared, largely based upon the first four or five years of the epidemic. I believe a number of doctors, certainly not all, have to deal with their own sensitivities about the homosexual and IV drug-using populations. They need to overcome any biases or prejudices that make it more difficult for them to deal with those groups or to appreciate the risk in the general population.

IMJ: *The IDPH survey showed that 65% of people think they could get AIDS from donating blood. Is there widespread fear that AIDS can strike those who donate blood?*

Dr. Turnock: That was a surprising finding. I believe it had to do with the way the question was asked. There are two groups represented in that 65%: one that inaccurately perceives that AIDS can be contracted by giving blood, and another subset of people who misunderstood the question. The question asked was, "Can you get AIDS from donating blood?" Maybe they interpreted it to mean, "Can you get AIDS from *donated* blood?"

The 65% statistic is clearly much higher than those of us in the public health field would expect. Only one in ten of those have stopped giving blood as a result of their concern about AIDS. If only 10% stopped

Mandatory testing on a low risk population is not cost effective. It gives a false impression that the disease is being controlled.

Our recent public survey showed that well over 90% of the population feel that their doctor is the best person to provide them with information about AIDS. The family doctor scores higher than the health department and even the Surgeon General.

giving blood, the other 90% probably really don't believe they can get AIDS from giving blood. If I thought I could get AIDS from giving blood, it would be an easy thing to give up.

IMJ: *Do people feel that the blood banks are now safe? Are there more people donating blood for elective surgeries than before?*

Dr. Turnock: I think there's been a movement toward designated donations, which complicates the whole picture. We have to circulate more complete information about how safe the blood supply currently is. Blood centers are having major shortages related directly or indirectly to AIDS fears. That's a real disservice to individuals who need those blood products. It's an area where we need to clarify some of the sensory overload and the confusing messages that have come across to the public.

IMJ: *Is media attention on AIDS out of proportion to its real threat when compared with cancer, heart disease and other serious or incurable illnesses?*

Dr. Turnock: I don't know that anyone can really pass sound judgment in that area. Much has been written on AIDS—on fears, misperceptions, hysterical reactions, new developments and constitutional and civil rights issues. In many respects, the media coverage is justified because AIDS is certainly a most important new health problem.

On the other side of that coin, there's no consistent sense to reporting what it is that people really need to know about AIDS—in a way they can use that information every day. A story one day might report that "scientist reports AIDS is spread by mosquitoes." But the other side of the story—that virtually everybody in civilized medical spheres knows that AIDS can't be contracted in that way—often goes unreported. The sensory overload on AIDS information leads people to turn off the information they need to know and use.



Despite how much they know and how much they've heard, the key question is what they're doing about it—whether or not they're translating AIDS information into protective or preventive action.

Illinois AIDS Cases By Transmission Category

	Number Diagnosed	% of Total
Homosexual/Bisexual Male	695	77
Homosexual Male and IV Drug User	50	6
IV Drug User	48	5
Hemophiliac	13	1
Heterosexual[1]	24	3
Transfusions	40	4
Child Born to Infected Parent(s)[2]	7	1
Undetermined[3]	26	3

[1]Includes 14 persons who have had heterosexual contact with a person with AIDS or at risk for AIDS and 10 persons born in countries were heterosexual transmission is believed to be the major mode of transmission.

[2]Epidemiological data suggests transmission from infected mother to child before, at, or shortly after birth.

[3]Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed, loss to follow-up), patients who are still under investigation, and interviewed patients on whom no risk was identified.

Data on file as of April 30, 1987.
Courtesy, Illinois Department of Public Health

I would like to see more consistent reporting on AIDS, and a sense of responsibility by the media. A responsible media approach can help to control the disease, instead of merely trying to report what's newsworthy.

IMJ: *Should doctors be involved in safe sex education for their adolescent patients?*

Dr. Turnock: Safe sex education itself has to be put in perspective. It's certainly not the primary, or even the most effective control measure for the spread of AIDS. Doctors should be involved in providing information, education and support for their patients on how to prevent exposure to the AIDS virus. Physicians should be involved in programs that focus on effective control measures, including abstinence, mutual monogamy and instruction in safe sexual practices where appropriate.



Physicians should be involved in programs that focus on effective control measures, including abstinence, mutual monogamy and instruction in safe sexual practices where appropriate.

IMJ: *AIDS is a "reportable disease" in Illinois, but are the numbers underreported because patients really die from AIDS complications rather than AIDS itself?*

Dr. Turnock: It's safe to say that AIDS deaths are underreported. There's no absolute certainty that we're capturing 100% of the cases. But I don't think it's significantly underreported. IDPH and other state health departments carefully review death certificates to identify conditions that might be misdiagnosed or mislabeled. We capture the vast majority. I don't believe the underreporting goes beyond a few percent.

IMJ: *Would you recommend that people who have had multiple blood transfusions voluntarily seek an AIDS test?*

Dr. Turnock: That's good advice, but it's not really that simple. The answer depends upon how many blood units they got, when they got them, where they got them and where the blood came from. There are a lot of variables. But there's obviously some increased risk in having received multiple transfusions, especially those which would have occurred shortly before the testing program began in the nation's blood centers.

IMJ: *What about doctors and other health care workers who have AIDS? Do you think they should have medical staff privileges limited or restricted? Should they be required to tell their patients that they have AIDS?*

Dr. Turnock: Physicians who have AIDS or who have been infected with the virus causing AIDS should be allowed to continue work unless their clinical condition prevents it. Truly, there is no risk to their patients or to their co-workers, unless they're engaged in the kinds of risk behaviors that transmit the disease.

I don't believe physicians with AIDS should be required to inform patients, because they really present no risk. Patients have a right to know some things. But they certainly don't have the right to know very personal and private things about their physician unless there is some risk presented by those personal facts.

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IMJ: *How is AIDS affecting health care costs in Illinois? Are there any projections on how much society will pay for this epidemic?*

Dr. Turnock: There are many pro-

jections, and they tell a very dismal story. If current trends continue we will have had 20,000 cases in Illinois by 1991. Ten thousand of them will have occurred in a single year. We will be incurring medical care costs of probably $1—$2 billion. About half of that will probably be borne by the public sector, largely through Medicaid and perhaps Medicare.

There will be an incredible burden on hospitals. And there will be an increasing burden on health and supportive services outside of hospitals—nursing homes, home health services, hospice care, respite kinds of services, and other homemaker services that might be provided to AIDS victims in their residences.

I think we also have to look at another side of the cost issue: lost productivity. Society will lose the productivity, contributions and tax dollars of AIDS victims, because the disease impacts a very young, able and productive age group. There will be an incredible fiscal burden.

Next year, AIDS will become one of the 10 leading causes of lives lost prematurely. And the year after that, it will move up to fifth or sixth. So it will rank just behind such conditions as heart disease, cancer and accidents. But it will be ahead of many of the other common causes of years of life lost prematurely. That's a very good indicator of the burden it will place upon society.

Illinois AIDS Cases By Age

	Number Diagnosed	% of Total
under 13	11	1
13-19	6	1
20-29	199	22
30-39	389	43
40-49	202	22
over 49	96	11

Data on file as of April 30, 1987
Courtesy, Illinois Department of Public Health

Illinois AIDS Cases By Race/Ethnic Origin

	Number Diagnosed	% of Total
White	585	65
Black	242	27
Hispanic	68	7
Other	8	1

Data on file as of April 30, 1987
Courtesy, Illinois Department of Public Health

The general public too often sees AIDS as a disease of homosexuals or IV drug users. They don't appreciate the risk they have in their own lives. And they don't realize what they ought to be doing to protect themselves.

IMJ: *Will Illinois "catch up" with states like New York and California, in the cost and number of AIDS cases?*

Dr. Turnock: We're lagging behind these states because AIDS started there earlier. That's very favorable for us. It means we've had two more years to learn about the disease and begin to implement programs among the most affected groups. I think that two-year time lag will eventually result in AIDS having far less impact in Illinois than California, New York, New Jersey, Florida or Texas. Those are the states that are well ahead of us in the number of AIDS cases.

IMJ: *What about insurance for AIDS victims? Some of them have it, but many do not. Should insurance companies be allowed to test for AIDS before offering health or life insurance policies? If not, how will AIDS care in Illinois be financed?*

Dr. Turnock: Even if insurers do mandate AIDS tests, Illinois provides mechanisms to help uninsured AIDS patients. One is the Comprehensive Health Insurance Program (CHIP) recently enacted in the General Assembly. Medically high risk people unable to get other insurance can purchase it from CHIP at a somewhat higher rate through a state-funded pool. It would place a big burden on that pool, but it would still assure availability of insurance coverage.

The biggest concern remains with those who don't have any resources. That, no doubt, will result in an increased load on the public sector to pay for health care costs of AIDS victims.

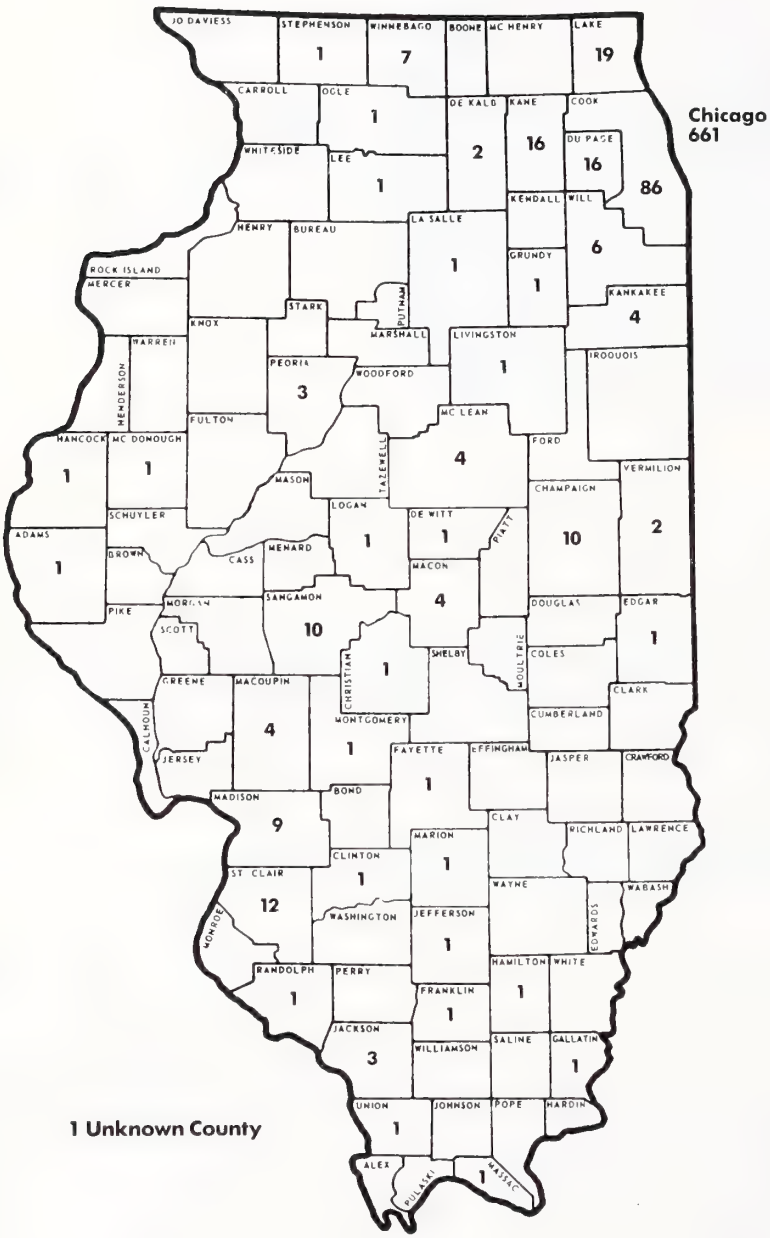
IMJ: *What is the state AIDS hot-*

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Monthly Statistical Update as of April 30, 1987

Number of new AIDS cases this month: 48

Total Cases: 903 Males: 871 Females: 32



1 Unknown County

Courtesy, Illinois Department of Public Health

line, and what is its purpose? Can physicians use it?

Dr. Turnock: Anyone can use the state AIDS hotline. It's an 800 number (1-800-AID-AIDS) currently available 12 hours a day, seven days a week. It provides basic information and referral services and assists individuals in locating a testing center, finding a doctor or other medical services. It's a front line resource. Physicians can certainly use it. I'm sure they don't need it for the information, but it might assist them in referral of individuals for testing or treatment services. It can serve that purpose as well as many others.

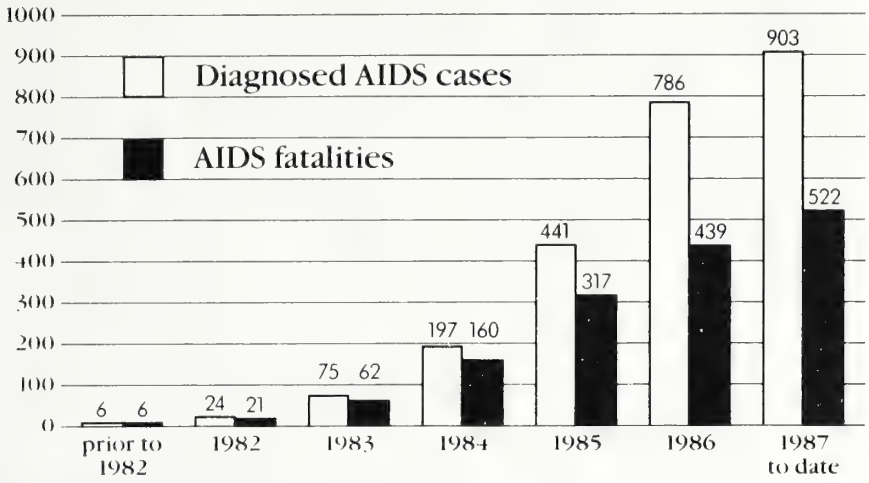
IMJ: *Will the IDPH funding for AIDS education continue? If so, will the campaign's future focus remain the same?*

Dr. Turnock: We've been focusing educational efforts heavily on the traditional high risk groups because that's where there are many infected people. It's also become very clear that it's time to get out to the general population. That, obviously, needs to be an ongoing effort. It involves trying to communicate to all age groups and all parts of the state, asking them to identify risk behaviors in their own lives that need modification to avoid exposure to the virus.

Since we know AIDS won't go away tomorrow or next year, we should institutionalize ongoing education programs. It also implies that we ought to be teaching our children about AIDS, *before* they develop risk behaviors or lifestyles that place them at risk. We need to provide them with information that will lead them to more responsible choices, hopefully toward abstinence and faithful monogamous relationships.

But we have to avoid getting caught up in education itself as the objective. We're really using education to produce changes in behavior, changes in actual day-to-day life. We're trying to change people's lifestyles through education and other approaches. But it's not enough to sit back and say, "We've

Cumulative AIDS Cases in Illinois



Data on file as of April 30, 1987
Courtesy, Illinois Department of Public Health

Next year, AIDS will become one of the 10 leading causes of lives lost prematurely. And the year after that, it will move up to fifth or sixth.

distributed 11 million pieces of paper to Illinois residents. We've sent around 500 public service announcements. We've put up 3,000 cards in the trains and buses."

Knowledge isn't enough. It's not enough to know AIDS is dangerous. People have to act on that knowledge. It's the same problem we've had in public health with other unhealthy lifestyles and behaviors. The past doesn't suggest that we're going to be totally successful in the future, but I think AIDS education can be an exception.

I think AIDS is a different animal. It's a deadly disease. A scary disease. Therefore, our educational efforts will probably be more successful than we've seen with tobacco or alcohol or diet and exercise. People can easily decide, "No, I don't want to die." ◀

Bernard J. Turnock, M.D., M.P.H., is director of the Illinois Department of Public Health. He joined IDPH in 1985, after serving three years as the Chicago Department of Health's deputy commissioner. Dr. Turnock now presides over a $220 million IDPH budget and a staff of 1300 public health professionals. After receiving his M.D. from the University of Illinois' Abraham Lincoln School of Medicine, Dr. Turnock completed a masters degree in public health at the University of California, Berkeley. He is board certified in preventive medicine and trained as a pediatrician. Dr. Turnock has published many articles covering newborn and perinatal care and infant mortality. In addition to his ISMS membership, Dr. Turnock is a fellow in the American College of Preventive Medicine, and a member of both the American and Illinois Public Health Associations. Dr. Turnock has led Illinois government's battle against the spread of AIDS. He is a co-founder of the Chicago Area AIDS Task Force.

AIDS as a Handicap

The Illinois Department of Human Rights has determined that AIDS is a handicap as defined by the Illinois Human Rights Act, and that AIDS patients should be entitled to the protections of that Act. The Department's ruling has not yet faced legal challenge, nor has it been reviewed by the Illinois Human Rights Commission.

The Illinois Human Rights Act provides protections against discrimination in employment, housing, financial credit and public accommodation. Patients seeking more information about its provisions may contact the Illinois Department of Human Rights. Their Chicago offices are at 100 W. Randolph, Suite 10-100, Chicago IL 60601 (312-917-6200). Their Springfield office is located at 623 Stratton Building, Springfield IL 62706 (217-785-5100). ◀

IDPH Survey of Illinois Adults

Awareness and Attitudes About AIDS

The Illinois Department of Public Health recently completed a survey of Illinois citizens, seeking to assess educational needs with respect to AIDS information. The survey brought out a high level of sophistication regarding the basic facts about the disease, and also identified areas of public confusion. More than 90% cited their physicians as a credible source of information about AIDS. The IDPH summary of their survey results is reprinted below.

A statewide survey was commissioned by the Illinois Department of Public Health to serve as a benchmark attitude study prior to the launch of a statewide AIDS education campaign for the general public. The survey was conducted by telephone between January 16 and January 26, 1987, by Richard Day Research Inc., of Evanston, Illinois. The report is based on a random sample survey of 800 Illinois residents between the ages of 16 and 64. The data match the regional, racial and educational distribution across the state, based on adjusted 1980 census information.

Scope of the Survey

The survey probed awareness and understanding of AIDS in five general areas. Queries considered general awareness of AIDS, knowledge of the ways in which AIDS is contracted, concerns about AIDS spreading to the general public, policy questions regarding the role of government and education and information resources available on AIDS.

Survey Results

Respondents' perceptions of how much they know about AIDS tracks well with what they actually do know about the disease. Slightly over one-third of the respondents said they "did not know much" about the disease.

Those who are the least knowledgeable also are the most fearful of AIDS: blacks, Hispanics, Chicago residents, those with low levels of education and income. The youngest (under 18) and the oldest (over 45) also fit this profile.

Those who are the most knowledgeable also are concerned about the disease. They are most likely to have high levels of education and income and fall within the ages of 27-44. They also are more likely than average to be single and under 42 years old.

Eighteen percent of all those polled were afraid they might get AIDS. Except for Hispanics, among whom fear of the disease was extremely high (59% said they were afraid they might get the disease), no more than a third of any group said they were afraid of contracting AIDS. Only 23% of single respondents under the age of 28 said they were afraid of getting AIDS.

Nearly all respondents knew they could get the AIDS virus by using a hypodermic needle that someone with AIDS had just used (96%). Nearly all knew that one *cannot* get the virus by such casual contacts as working in the same office as a person with AIDS (93%) or by touching someone with AIDS (90%).

The most common misperceptions regarding the transmission of AIDS include the belief that it is possible to catch AIDS by kissing, from a toilet seat or by giving blood.

Slightly over three-quarters of the respondents said they had done nothing in particular to avoid getting AIDS. The most frequent response given by those who have done something to avoid AIDS was reducing the number of sexual partners. This answer was volunteered more often than average by men and by persons between the ages of 25 and 34.

The majority of married respondents (69%) and single respondents

(54%) said they have not used a condom to reduce the chance of contracting AIDS, although 29% of singles say they have used a condom for this reason.

The majority of respondents feel all three levels of government (federal, state and local) are very responsible for education, research and treatment of AIDS, with the federal government bearing most of the responsibility.

The people of Illinois are generally sympathetic to the plight of AIDS and its victims. Most (79%) think children with AIDS should be allowed to go to school; nearly as many (73%) think more should be spent on AIDS awareness and education, and a like number (72%) think more should be spent on AIDS research. Nearly two-thirds (65%) oppose quarantine for those with AIDS and 58% think more should be spent on treatment of AIDS victims.

Respondents were optimistic about the prospects for a cure—almost 90% felt there would be one within the next 10 years, and 67% thought there would be a cure within the next five years.

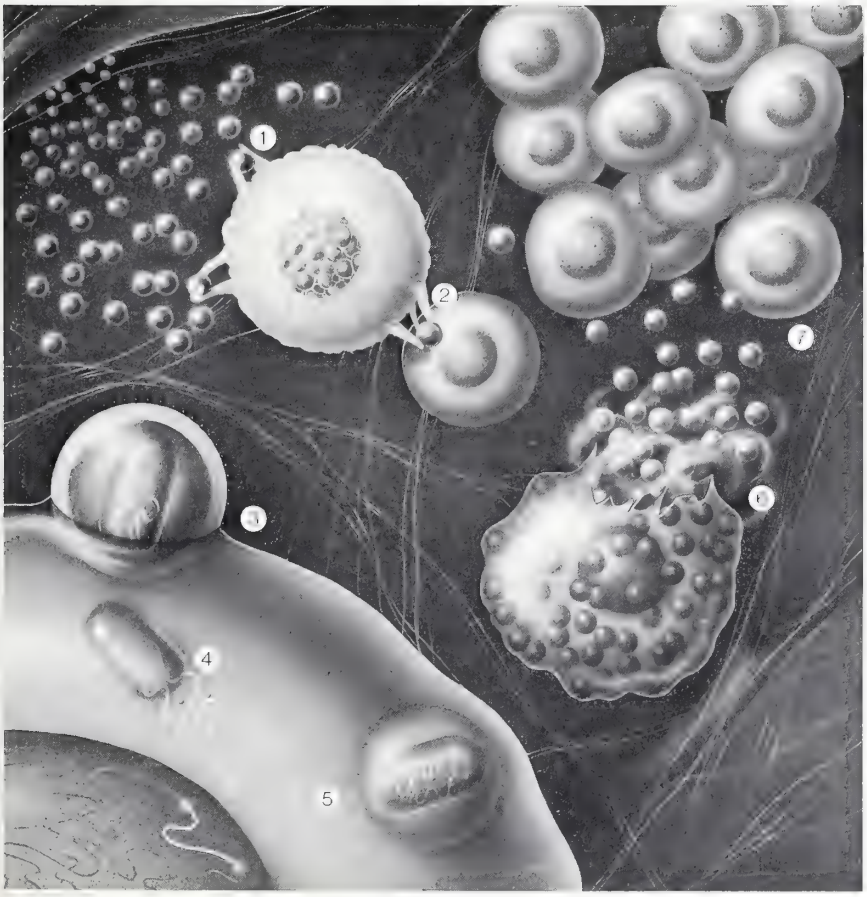
The great majority of respondents (85%) agreed that sex education programs are an important way to combat AIDS. Forty-five percent of all respondents felt that programs should begin in elementary schools and 34% believed these programs should begin at the junior high school level.

More than 80% of every group polled agreed that both their personal physicians and the Illinois Department of Public Health are believable sources regarding AIDS. (Editor's Note: More than 90% of all respondents found their physicians and IDPH to be credible sources. This figure reflects approval rates as low as 80% *among some groups* included in that total.)

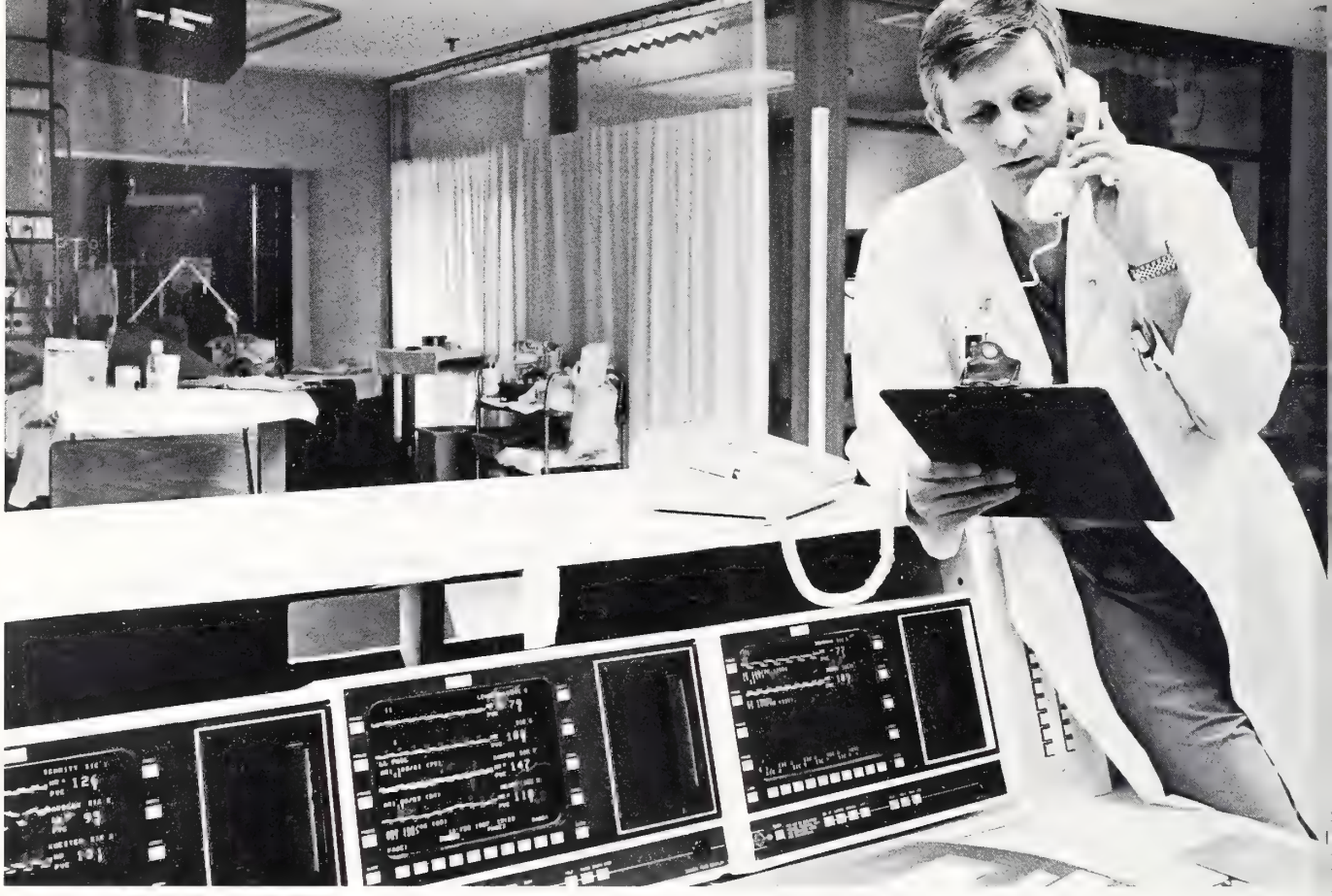
Forty-seven percent of respondents felt the news media was believable regarding AIDS coverage; an equal number thought the news media could not be considered a believable source. The latter group was more likely to be young respondents, suburban and rural downstate residents, men, and those employed in medicine.

The majority (58%) supported the idea of required blood testing for exposure to the virus that causes AIDS; however only 17% thought everyone should be tested, 10% felt homosexuals should be required to be tested; 2% favored testing for hospital and medical workers, and only 1% favored required testing for those about to be married.

Life Cycle of the AIDS Virus



1. The AIDS virus enters the body in the blood stream or semen. It is first engulfed by a macrophage.
2. The macrophage presents the living AIDS virus to a T4 lymphocyte, a key component of the body's immune system.
3. Proteins on the virus' surface react with the T4 cell membrane causing it to form a vesicle, drawing the virus inside.
4. Once inside the cell, the virus sheds its protein envelope, releasing its genome.
5. Viral RNA replicates to viral DNA which fuses to the T4 DNA. The infected T4 DNA produces new viral RNA and proteins, forming new viruses.
6. New viruses form at a rapid rate and bud from the T4 cell membrane, often destroying the cell.
7. Once released, the new AIDS viruses attack other T4 cells.



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Exchange Insights
ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

How to Avoid the "Failure to Diagnose" Claim

THE BAD NEWS IS: One of every physician's greatest risks of being sued is for a "Failure to Diagnose" allegation. **THE GOOD NEWS IS:** Implementation of some simple safeguards can substantially reduce your risk of suit for "Failure to Diagnose" claims.

The reports of malpractice cases tend to zero in on the bad results/specific damage to the patient—without identifying system safeguards which could have protected the physician from suit. The focus of this article will be on what can be done to avoid and defend "Failure to Diagnose" claims.

Many "Failure to Diagnose" cases originate in the outpatient environment. Physicians need to be aware that large malpractice awards in "Failure to Diagnose" cases have resulted when the patient was seen only one time by the physician involved. In some cases, the patient was not even seen for the condition for which he/she later sued. Consider a Texas case:

The patient saw the physician for cough and chest pain. The physician saw a mole-like growth on her arm but did not identify it, perform a biopsy or warn the patient. Another doctor diagnosed melanoma three months later. At surgery, lymph node resection was negative for metastasis and the patient recovered uneventfully. She sued the first doctor for failure to diagnose the potentially fatal disease. The surgeon testified that delay in diagnosis did not change the mode of treatment; and since no metastasis was found, her life span had not been shortened. At the first trial, the district court gave summary judgment in favor of the physician. The appeals court overturned the decision. They decided the malignancy must have grown in the three-month interval, "at least by some imperceptible amount" and that the growth of a deadly malignancy constitutes an injury[1]. This places short-term and outpatient care providers at a special risk.

Problems and Solutions:

Based upon our experience and review of a variety of "Failure to Diagnose" claims, the following recommendations can help protect the physician from risk. Breast cancer is used as an example, although the principles are applicable to all types of "Failure to Diagnose" cases.

Example: Breast Cancer Claims—Any "Failure to Diagnose" cancer case is more difficult to defend because the American Cancer Society stresses that early diagnosis can result in cure. Defense attorneys tell us this is a difficult position to discredit in a juror's mind. Therefore, any delay in diagnosis which can be attributed to the actions or inactions of the physician can make the defense difficult.

Preventable Problems in "Failure to Diagnose" cases are:

1. Lack of Documentation: The most common problem is the failure to fully describe the breast lump in the medical record. A note which says "Mass, left breast" is an automatic two strikes against you should the patient at any time in the future develop cancer in the left breast. It does not matter whether or not the cancerous lump was the same lump that you originally examined because your records can't prove it wasn't. The patient will testify that it was the same lump you examined. The record of any mass should include the length of time it has been present, the location, size, consistency, degree of tenderness, whether it is fixed, and any other informa-

tion which clearly identifies the mass. The plan for follow-up or further treatment should also be documented.

2. Failure to Follow-Up: Would you like to be the defendant in the following case? The records show that a patient's breast mass was first noted five years ago. The family history documents the patient's mother and sister have had breast cancer. Notes in the record say the patient should have a mammogram or a consultation with a surgeon. The patient is seen by multiple physicians within the group frequently over the course of the next five years. No chart note during that period mentions the results of the mammogram, the surgical consultation, or any subsequent breast exam. This patient, like so many "Failure to Diagnose" cases fell through the cracks within the group's procedural and record keeping systems.

3. Eliminate Cracks in the System:

A. Review Your Notes: One simple, very basic prevention step is to always review the note of the patient's last visit. Check to see if there was a symptom which should be re-evaluated at this visit. A patient, particularly a patient who fears cancer, may psychologically depend upon you to bring up the topic again. The patient may think that since you know about the lump, if it was important you'd check it again. Yes, that can be contributory negligence on the part of the patient, but it won't eliminate your liability.

B. Maintain a Problem List: A Problem List which lists all unresolved problems can be particularly useful in avoiding a "Failure to Diagnose" case when the patient is frequently seen. A note to "recheck the breast in 6 months" can get lost in the multitude of progress notes generated for other conditions in the interim.

C. Establish Follow-Up Safeguards: If you send a patient out for a test or a consultation, have a system which confirms that the test or consult was done; and what results were found. A simple system for tracking consultations is to use a three copy form which provides a tickler copy for your file, a copy for the consultant's file, and a final copy back to your records. Another easy system to track results is to review and initial all reports before they are filed in the patient's medical record. You will also want to establish a "tickler system" for notifying the patient of abnormal results and the need for further treatment or follow-up.

D. Educate the Patient: Make the patient aware of the importance of follow-up. Give instructions to the patient which clarify the symptoms which require follow-up prior to the next scheduled re-check (i.e. increase in size of lump, etc.).

Consider the Worst Diagnosis:

Many "Failure to Diagnose" cases involve serious disease processes which have some symptoms similar to common ailments. The physician most frequently gets in trouble when he/she diagnoses the usual minor condition and it was the more serious one this time. Is it indigestion, or is it a myocardial infarction? To a degree, you can minimize your risk of a "Failure to Diagnose" case if your records clearly document that you considered all alternatives. It is easier to defend a case where the Differential Diagnosis says: "Rule out Myocardial Infarction, Probably Indigestion" than it is where the only diagnosis the physician seems to have considered was "Indigestion." The negatives recorded in a physical examination can also provide protection for you. "Pain does not radiate" is a greater protection than "negative" recorded under symptoms.

Telephone Diagnosis:

Many physicians who follow a patient for a prolonged period of time frequently increase their claims risk by the practice of medicine by telephone. In instances where you are relying upon the patient's description of symptoms rather than physical examination, documentation becomes even more important. Your notes should include such statements as: "Upon questioning, the patient says there is no radiation of pain to the arms"; and "Patient says she has no other symptoms at this time."

Staff's Role:

Costly "Failure to Diagnose" cases have occurred when staff personnel have not been properly trained to obtain complete or crucial details when they take a message from the patient. The failure of staff to recognize the potential seriousness of postoperative symptoms is a particular risk. In a knee surgery case, the postoperative patient called complaining of chest pain. The surgeon's office staff referred her to her family physician because they did not recognize any connection between the surgery and the symptoms. A "Failure to Diagnose Pulmonary Embolism" case resulted. Physicians should write protocols which delineate patient symptoms that require staff to promptly notify the physician.

Summary

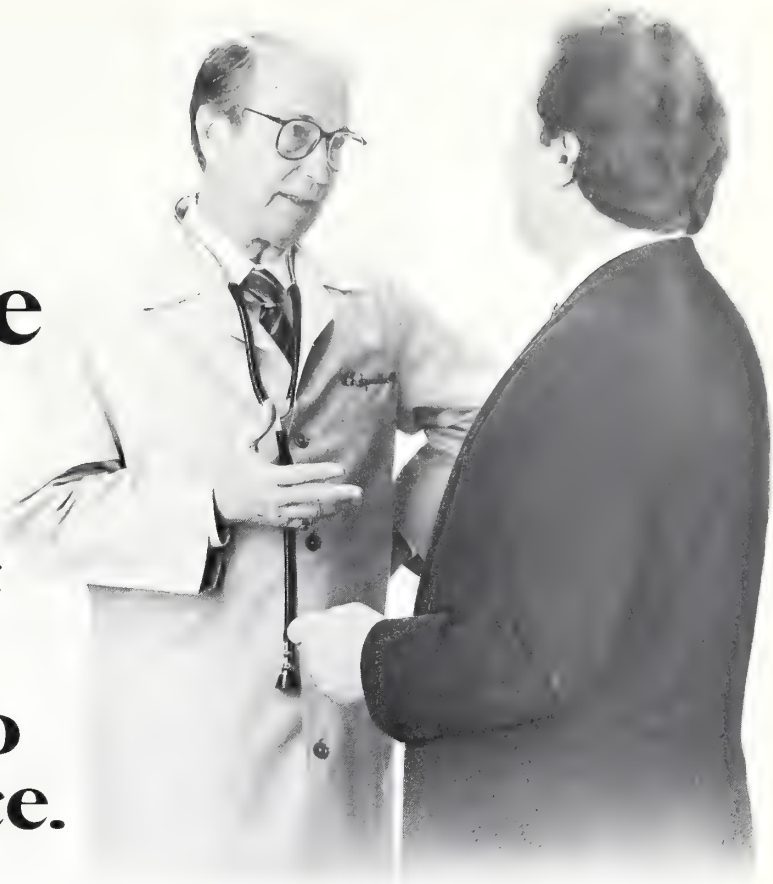
Like many diseases, prevention of a malpractice case is much easier than the "cure" process via litigation. If you inculcate good prevention principles in your daily practice you can minimize risk of suit and concentrate on practicing good medicine. That's what every physician wants to do anyway, isn't it?

1. Texas Civil Appeal 608 S.W. 2d 697

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Working as a Team

By Lynn Kassel (Mrs. Wayne), ISMSA President

As the 1987-1988 ISMSA Board of Directors launches its plans for the year ahead, it is important to be aware of our focus in the areas outlined below. Working as a team, ISMS and the Auxiliary can accomplish a great deal to combat the public's negative views of physicians in relationship to the changes occurring in medicine. Be aware of what your county auxiliary is accomplishing, especially in health and legislative areas.

Health Projects

The AMA announced its focus on **adolescent health** this past year. Your state and county auxiliaries have been working with this issue for a number of years now. Beginning with **drug abuse,** the Auxiliary continues to provide education programs in the schools, community seminars and guides for parental use. **Teen suicide prevention** was introduced in 1985 with the help of ISMS, and projects were initiated in eleven counties. An intervention program for the schools has been developed by an Illinois physician and his spouse and will be ready for distribution this year. Our auxilian has been appointed to Governor Thompson's Task Force on Adolescent Welfare as a result of the outstanding work in this area. Our program has served as a model for many other states, and it continues to grow under our expanded committee. **Adolescent sexuality** will be introduced at a seminar in Oak Brook this November as a part of ISMSA's health program.

Many other health projects continue throughout the auxiliary network . . . . seat belt and infant restraint programs are receiving new emphasis through the GM-AMA program which focuses on the myths surrounding seatbelt usage . . . immunization clinics . . . organ donation . . . AIDS education . . . mammography screening . . . to name only a portion of the community projects involving the medical family.

AMA-ERF

Through a variety of fundraising efforts, the Auxiliary has contributed many thousands of dollars over the years. Illinois has been an award winning state at the AMA Auxiliary Convention in the past. This year, close to $32,000 will be the Illinois Auxiliary gift.

Family Advocacy

A number of programs to assist the medical family have been initiated through Auxiliary. This year a committee with representatives in the areas of loss of spouse, death of a child, living with an ongoing illness, malpractice support, and impairment will be available through a phone number published in the ISMSA newsletter, *PULSE.*

Legislation

Illinois has been a leader in programs involving legislation. Our internship program in Springfield serves as a model for others. Auxilians lobbied for three days at the State Capitol, with briefing and training from ISMS provided by the ISMS Governmental Affairs office. Their efforts in the '85 and '87 rallies have proved invaluable. Working on campaigns for local candidates brought Illinois a runner-up award from AMPAC this year. As a result of outstanding effort, one of our members has been hired as a legislative assistant in the Springfield office of her representative. There is an increasing demand from our members for legislative involvement, so new areas in this field are being considered.

Membership

Every organization needs to continuously study their methods of member recruitment and retention. ISMS and the AMA are increasing membership as new physicians join organized medicine to impact their future. **Teamwork** in this endeavor is crucial to Auxiliary. We need the assistance of county medical societies to encourage their members' spouses to join Auxiliary. It is their

only link to the medical family. If our newsletters don't reach home to inform the physician's spouse about matters affecting legislation, how can they assist when their voice is needed? We welcomed LaSalle County Auxiliary's organization this year and are working with other areas that have expressed interest. However, there is a large gap between the close-to-90 medical societies and 29 auxiliaries.

The ISMSA, through its relationship with the AMAA and their professional resource materials, continues to feed and encourage county auxiliaries. Our **Members-At-Large** sector (members without an organized auxiliary in their area) is beginning to grow as physician spouses become more politically active. Throughout our nearly 60 years of assistance to the medical society, Auxiliary has proven itself an able, willing partner in healthcare. If your spouse is not part of our network, won't you encourage support of the only organization combining the best interest of medicine and the physician as its goal?

For information on Members-At-Large membership (dues $30) call ISMSA, 312-782-2099 or write to ISMSA, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. ◀



ISMSA 1987-1988 Board of Directors: Seated from left Sherry Betsill, President-Elect, and Lynn Kassel, President. Standing, from left to right: Teresa Schmidt, Carole Taylor, Chariya Limanon, Ann Arida, Jane Klaren, Sharon Wilson, Sheila Minster, Susanne Webb, Sylvia Eberle, Evelyn Perlmutter, Nancy Hoffmann, Martha Hull, Gayle Dustman, Laura Hays, Miriam Geist, Livia Martinucci, Carol Gapsis, Phyllis Thielemann, Vivian Reardon, Pat Failor, and Pat Spadoni.

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Use of prophylactic knee braces by college football players was evaluated to ascertain its efficacy in preventing knee injuries. Data collected from 71 schools in 1984 and 61 schools in 1985 showed that players who wore knee braces had significantly more injuries to their knees than players who did not. However, the severity of injuries did not differ in the two groups. (Teitz, C., *et al.: J Bone and Jt Surg* 69A:1,2-9, 1987)

Vitamin supplements may be indicated in infants, pregnant or lactating women, and in people with unusual life-styles or modified diets. Vitamins in therapeutic amounts should be prescribed and supervised by physicians for various deficiency states, pathologic absorption or utilization, or for certain nonnutritional disease processes. (Council on Scientific Affairs, *JAMA* 257:14,1929-36, 1987)

Patients with symptoms of atherosclerosis of the internal carotid or middle cerebral arteries were randomly divided into a surgically-treated group and a medically-treated group. Extracranial-intracranial arterial anastomosis resulted in a worsened functional status which lasted 4.5 months beyond the perioperative period. Surgery did not reduce or significantly increase the risk of stroke, but did result in greater dysfunctions of speech fluency, transference, toileting, cutting food, pouring beverages, and dressing. (Haynes, R., *et al.: JAMA* 257:15,2043-46, 1987)

Fish-oil fatty acid supplementation appeared to be effective in alleviating some symptoms of active rheumatoid arthritis. Of patients continuing their usual medication, 19 were given placebo while 21 received capsules daily containing 2.7g of eicosapentanoic acid with 1.8g of docosahexenoic acid. After 14 weeks the treated group showed less fatigue and less number of tender joints, which correlated with the neutrophil leukotriene B-4 production. There was no statistical difference in the hemoglobin level, the sedimentation level, and the rheumatoid factor. No adverse side effects were reported and the beneficial effects lasted beyond the four week wash-out period. (Kremer, J., *et al.: Ann Intern Med* 106:4,497-503, 1987)

Medical involvement in air travel may increase when advice is sought by air travelers prior to flights, or by physicians traveling on airlines. Since August 1, 1986, aircraft have been required to carry medical kits mandated by the Federal Aviation Administration. Kits must contain a stethoscope, sphygmomanometer, oropharyngeal airways, syringes and needles, dextrose 50% injectable, epinephrine 1:1,000, diphenhydramine, nitroglycerine tabs and a first aid kit. The pilot may request your advice as a passenger physician to determine whether the plane should be diverted to the nearest hospital. Emergencies frequently encountered on the ground include hypoxemia to lung, cardiac or central nervous system organs. Dysbarism may result in barotitis, sinusitis, pneumothorax, abdominal pain, or ruptured viscus. Other syndromes may be caused by the effects of jet lag, motion sickness, or phobias. (Goodman, P.: *Post Grad Med* 80:8,54-66, 1986)

A cohort of 2,046 initially healthy men were followed for 14.9 years with serial determinations of urate levels. Gouty arthritis increased at an annual rate of 4.9% when urate levels were 9mg/dl or more, compared to a 0.5% annual incidence of gouty arthritis when the urate level was 7.0-8.9mg/dl and a 0.1% incidence rate for urate levels below 7.0mg/dl. Hypertensive patients exhibited a three-times higher incidence compared to normotensive patients. At final examination only 0.7% of participants had a serum creatinine level of 2.0mg/dl or more, with no evidence of renal deterioration attributable to hyperuricemia. This supports a conservative approach to the management of asymptomatic hyperuricemia. (Campion, E., *et al.: Am J Med* 82:421-6, 1987)

A high intake of potassium from food sources may protect against stroke-associated deaths. An initial 24 hour dietary potassium intake at base line was analyzed and followed for 12 years. This was then correlated with subsequent stroke-associated mortality in 859 men and women aged 50-79 years. A high dietary intake of potassium is associated with lower blood pressure. Its intake was estimated after initial blood tests by the dietary use of vegetables and fruit. The authors state that fruit and vegetables may also be of benefit in the prevention of cardiovascular disease and cancer. (Khaw, K., Barrett-Connor, E.: *N Engl J Med* 316:5,235-40, 1987)

A comparison among 56 neurologically-normal elderly volunteers and 102 age-matched patients with symptoms of transient ischemic attacks showed significantly higher serum cholesterol and triglyceride levels in the TIA group. In addition, cerebral blood flow was reduced in the TIA group. Hypertension, atherosclerotic heart disease, diabetes mellitus and cigarette smoking were also prominent among the TIA patients, compared to the age-matched normal controls. (Meyer, J., *et al.: Arch Neurol* 44:4,418-22, 1987) ◀

EKG

(continued from page 345)

Answers: 1. B, D, E 2. C, E

The ECG shows a normal sinus rhythm with a prolonged PR interval of 0.26 seconds or first degree AV block. The QRS duration is prolonged at 0.14 seconds with a tall, broad R wave in lead V_1 compatible with complete right bundle branch block. Deep S waves are present in leads V_4 to V_6. In the frontal plane, the QRS axis is rightward, creating a deep S in lead I and a QRS in lead III that is upright and slightly taller than the QRS in lead AVF. This right axis deviation is compatible with left posterior hemiblock. The combination of first degree AV block, complete right bundle branch block, and left posterior hemiblock is the ECG pattern of incomplete trifascicular block. This pattern is compatible with significant conduction system disease in the His-Purkinje system. Electrophysiologic studies in these patients with chronic bifascicular block are controversial. Even though a prolonged H-V interval can cause the prolonged PR interval and suggest incomplete trifascicular block, the risk of progression to complete AV block is small.[1] In the absence of symptoms suggesting intermittent complete AV block, electrophysiologic studies are not indicated and a pacemaker is not necessary. No ectopic rhythms were noted and no antiarrhythmic agents are indicated. In fact, antiarrhythmic drugs could further depress the conduction system and worsen the clinical situation.

This patient has a history suggesting unstable angina. Moreover, the angina is not well controlled with medication in the hospital. No evidence of a myocardial infarction was found. A coronary angiogram was recommended. The coronary angiogram showed a totally occluded left anterior descending artery, 95% obstructions in each of two diagonal arteries, a 95% obstruction in an obtuse marginal artery, and a 75% obstruction in a large dominant right coronary artery. The left anterior descending artery filled in a retrograde fashion from collateral circulation from the right coronary artery. The patient underwent successful aorta-coronary bypass surgery. No conduction problems occurred during this time. Almost a year later, this patient did develop intermittent complete AV block with symptoms and received a permanent demand pacemaker. In this patient, the coronary problem and the conduction system problem appeared at different times. ◀

Reference

1. R. C. Dhingra, *et al.*: "Significance of the HV Interval in 517 Patients With Chronic Bifascicular Block," *Circulation* 64:1265-1270, 1981.

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

August

Medicine

Specialty Review in Internal Medicine
For: Internists and medical subspecialists, Lecture, August 2-8, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $765. **Reg. Limit:** None. **Credit:** Category 1: 62 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Obstetrics and Gynecology

Gynecologic Surgical Techniques
For: Obstetricians and gynecologists. Lecture/Workshops, August 20-22, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $515. **Reg. Limit:** 90. **Credit:** Category 1: 21 hours; Other: 19 Cognates Formal Learning (ACOG). **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Orthopedic Surgery

Practical Management of Orthopedic Infections
For: Physicians. Seminar, August 7, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours. **Contact:** Loretta Giacoletto. **Photo:** (800) 325-9862.

Pediatrics

Specialty Review in Neonatology/Perinatology
For: Pediatricians and obstetricians. Lecture, August 24-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $640. **Reg. Limit:** None. **Credit:** Catetory 1: 57 hours; Other: 57 PREP hours (AAP). **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Psychogerontology

Third Congress of the International Psychogeriatric Association
For: Interested physicians. Symposium and workshops, August 28-31, Palmer House, Chicago. **Sponsor:** International Psychogeriatric Association, 259 E. Erie, Rm. 448, Chicago IL 60611. **Fee:** $320. **Reg. Limit:** None. **Credit:** Category 1: 1 hour of credit for every hour attended. **Contact:** Jill Cohen. **Phone:** (312) 908-1248.

Surgery

Specialty Review in General Surgery, Part I
For: General and specializing surgeons. August 17-28, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $880 **Reg. Limit:** None. **Credit:** Category 1: 96 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

September

Anesthesiology

The Use and Interpretation of Monitoring New Technologies
For: Anesthesiologists. Symposium, September 11-13, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 15.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Cardiology

Contrast Echocardiography Symposium: New Techniques in Profusion Imaging, Contrast Echo and Esophageal Imaging **For:** Cardiologists. Symposium, September 17-18, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $100. **Reg. Limit:** 125. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

General Practice

40th Annual Clinical Refresher
For: Interested physicians. Lectures and workshops, September 16-19, Chicago. **Sponsor:** Chicago College of Osteopathic Medicine, 5206 S. University Avenue, Chicago, IL 60615. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 18-24 hours. **Contact:** Marie Kowalsky. **Phone:** (312) 947-4606.

Psychiatry/Family Practice/Internal Medicine

Eating Disorders
For: Physicians and allied health professionals. Conference, September 22-23, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, and University of Wisconsin Hospital, Eating Disorder Program. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 20 hours; AAFP Prescribed and American Dietetic Association: credit pending; and University of Wisconsin CEUs: 10 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

October

Critical Care Medicine

Sixth Annual Chicago Critical Care Symposium
For: Physicians, physicians-in-training, and nurses. Lectures and panel discussions, October 15, Chicago Downtown Marriott Hotel. **Sponsor:** University of Health Sciences/The Chicago Medical School, Department of CME, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** To be determined. **Reg. Limit:** None. **Reg. Deadline:** October 15. **Credit:** Category 1: 24.5 hours; and AAFP Prescribed: to be determined. **Contact:** Ben Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Psychiatry

The Psychiatric Interview
For: Psychiatrists, Course, October 23-25, Holiday Inn Mart Plaza, Chicago. **Sponsor:** University of Chicago Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** 175. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

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FAMILY PRACTITIONERS: The Monroe Clinic, located 40 miles south of Madison, has openings in New Glarus and Brodhead, Wisconsin, satellites and new clinic in northern Illinois. Excellent benefits. Partnership available. Resources of 55-physician multi-specialty group. Contact Robert H. Rieder, Administrator, The Monroe Clinic, 1515 Tenth Street, Monroe, WI 53566; (608) 328-7381.

MEDICAL DIRECTOR for not-for-profit, urban community health center. Require strong community/public health commitment, BC in primary care area, experience in administration and clinical care. Desirable: Spanish knowledge. Salary commensurate with experience/skills. C.V. to: Executive Director, Erie Family Health Center, Inc., 1656 W. Chicago Ave., Chicago, IL 60622.

FAMILY PRACTITIONER: Eight doctor multi-specialty group, thirty miles southwest of Chicago seeks a young board eligible family practitioner (OB work available) to join growing practice. Incentive plan, profit sharing, relatively new clinic building with multiple ancillary services. Excellent practice opportunity in community with quality grade and high schools. Guaranteed salary with many fringe benefits for two years, then full partnership. Contact: Frank Schibli, Administrator, Hedges Clinic SC, 222 Colorado Avenue, Frankfort IL 60423; (815) 469-2123.

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HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has full-time private practice opportunities for the following specialties: board eligible or board certified internal medicine, and board certified family practice and pediatrics. Positions include income guarantee and no capital investment. For more information, contact Barry R. Trautman, 3663 Lindell, St. Louis, MO 63108; (800) 443-3901.

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GENERAL SURGEON for lovely downstate Illinois community (city 6,000; county 18,000). Growing, progressive hospital with a tradition of excellence. Region offers urban and rural amenities. Guaranteed income practice options available. Contact: Dr. Wendell C. Trent, Memorial Hospital, West State Street, Lawrenceville, IL 62439; or (618) 943-1000 (collect).

PHYSICIANS NEEDED: Part-time/full-time for family practice, OB/GYN and pediatrics in Chicagoland area. Send resume to All Management Consultants, P.O. Box 2237, Des Plaines, IL 60017.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has part-time and full-time opportunities available for physicians in emergency department, clinic and locum tenens work. Excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman, Healthline Physician Services, 3663 Lindell, St., Louis, MO 63108; (800) 443-3901. We are presently recruiting for emergency departments in St. Louis city and metropolitan area.

ILLINOIS ACADEMY of Family Physicians has available an opportunity service for its members to use. IAFP has detailed information concerning over 150 opportunities of different types throughout the state. To receive complete information, mail your C.V. to IAFP—1200 Harger Road, Suite 722, Oak Brook, IL 60521.

FAMILY PRACTITIONER. Board certified or eligible to join 11 physician, expanding multispecialty practice in northern Wisconsin. Clinic adjoins JCAH hospital. Rural location with abundant outdoor recreational opportunities, small four year college. Excellent salary and benefits. Call collect (715) 532-6651 or send curriculum vitae with names of references to: John Smylie, Administrator, Marshfield Clinic—Ladysmith Center, 906 College Avenue W., Ladysmith, WI 54848.

EVANSVILLE, INDIANA. Immediate position available for board certified family practitioner in busy, growing network of ambulatory care centers. Excellent income. Flexible scheduling. Contact MEC Medical Centers, 3844 First Avenue, Evansville, IN 47710, Attn: Rebecca Parker.

INTERNIST, BC/BE, Needed to join four physician practice. $9,000 per month salary, possible bonus, plus full benefits. Full partnership available. Located one hour from Memphis, Tennessee, on I-55. Send C.V. to: Merrill J. Osborne, M.D., Tenth and Highland Streets, Blytheville, AR 72315; or call (501) 762-5360.

WANTED: FULL TIME PHYSICIAN for industrial medical practice. Send resume to Box #2068 c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

OUTSTANDING OPPORTUNITY For board certified (or eligible) ophthalmologist. Guaranteed $100,000 first year salary plus benefits with opportunity to become partner and within a few years sole owner. Very successful well-balanced practice with considerable surgery. Completely equipped. Laser available. Beautiful new free-standing building close to progressive hospital complex in mid-

western city of 75,000, metropolitan area approximately 125,000. Excellent housing, education, and cultural opportunities. Write Box #2067, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GYNECOLOGIST for full time office practice, with an interest in infertility, is wanted to join a five physician OB/GYN department in a multi-specialty clinic. Attractive location in western Chicago suburbs. Very good family opportunities and professional growth. Forward C.V. to Dr. Joseph J. Nigro, 454 Pennsylvania Ave., Glen Ellyn, IL 60137.

PACIFIC NORTHWEST. Wenatchee Valley Clinic, an 105-physician, multi-specialty group practice with seven satellite locations is seeking the following physicians to join the main facility in Wenatchee: pediatrician, allergist, nephrologist, general internist, and psychiatrist. Excellent compensation and benefit packages available. Wenatchee, population 45,000, is located on the Columbia River in the foothills of the Cascade Mountains, providing excellent recreational opportunities in a family-oriented rural setting. If interested, send C.V. to Dr. Gerald Gibbons, Medical Director, Wenatchee Valley Clinic, 820 N. Chelan Avenue, Wenatchee, WA 98801; or call (509) 663-8711, ext. 205.

ARIZONA-BASED PHYSICIAN Recruiting firm has opportunities coast-to-coast. "Quality Physicians for Quality Clients since 1972." Call (602) 990-8080; or send C.V. to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252.

POSITION NOTICE: Chair/head, department of psychiatry and behavioral medicine. The University of Illinois College of Medicine at Peoria seeks a chair/head for its department of psychiatry and behavioral medicine. Candidates should qualify for appointment as associate or full professor. Requirements: M.D. degree with certification in psychiatry, Illinois licensure, demonstrated teaching excellence, and research experience. The University of Illinois is an affirmative action/equal opportunity employer. Position description available on request. Send C.V. and names of 3 references (or 3 letters) to A.W. Holmes, M.D., Chair, Psychiatry Search Committee, UICOM-P, Box 1649, Peoria, IL 61656; (309) 671-8421. Applications accepted until July 1, 1987.

FAMILY PRACTITIONER. Marshfield Clinic—Durand Center is seeking a board certified/board eligible family practitioner to join another family practitioner in an established office based practice in western Wisconsin. Rural location with abundant outdoor recreational opportunities. The Durand Center offers the autonomy of a private, primary care practice plus the financial and professional resources of Marshfield Clinic, a 250-physician multi-specialty group. Full hospital privileges at the local hospital in Durand. Excellent salary and fringe benefits. Please send curriculum vitae to: Robert Peterson, Director, Regional Centers, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449. Or you may call collect (715) 387-5498.

SEEKING DIRECTOR for industrial medicine clinic and emergency department based in moderate volume hospital. Attractive compensation and malpractice insurance provided. Benefit package available. Contact Emergency Consultants, Inc., 2240 S. Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

ORTHOPEDIC SURGERY—opportunities throughout the Midwest and Colorado. These positions offer both general orthopedic practices, along with subspecialized training. Partnership and group settings. Contact: Jean Malkasian, 250 Regency Ct., Waukesha, WI 53186; (414) 785-6500 (collect).

MEDICAL DIRECTOR/CONSULTANT wanted for nationally expanding smoking cessation corporation. Full or part time position requiring a combination of patient care, program development, public relations, and media publications. Ideal candidate will be a primary care physician, have experience and/or interest in smoking cessation and preventive medicine, and possess excellent communication skills. Contacts in smoking cessation research and development beneficial. Send C.V.s to Box #2069, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

PRIMARY CARE PHYSICIANS—Arizona based physician recruitment firm has various opportunities for BC/BE internists, FP's, and pediatricians coast-to-coast. For further information, contact Mitch Young at (602) 990-8080; or send C.V. to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252.

ILLINOIS (Chicago, West & Central Areas): Seeking emergency medicine physicians for full time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

GALESVILLE, WISCONSIN—Family practice. Immediate family practice opportunity available in rural community—population 1,300 with service area of about 8,000. Newly remodeled, fully equipped branch office is part of 51-physician multispecialty group with 16 family physicians. Diverse subspecialty backup and on-call coverage provided. 23 miles from 350-bed, full-service hospital in LaCrosse. Clinic offers competitive compensation package, including first year guarantee and excellent benefits. Galesville is nestled amidst the picturesque bluffs of southwestern Wisconsin. Year-round recreational resources nearby. Contact P.S. Shultz, M.D., Medical Director, Skemp-Grandview-LaCrosse Clinic, 815 S. 10th St., LaCrosse, WI 54601. Phone (608) 782-9760.

SITUATIONS WANTED

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box #2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DIAGNOSTIC RADIOLOGIST: Board certified, interventional and imaging fellowships, experienced in all modalities, seeks locums short term. Available most weekends, some weeks including weekdays. Reply to Box #2051, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WANTED TO BUY. General practice or general practice with general surgery. Could take over the practice immediately. Reply to Box #2063, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED GENERAL Surgeon seeks suitable position. Willing to do some general practice. Will consider HMO and urgent care centers. Reply to Box #2062, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WANTED PRIVATE GENERAL or internal medicine practice. Chicago or suburbs. Reply to Box #2065, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy at (312) 337-4221.

FOR SALE, LEASE OR RENT

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)662-1664 or (312) 244-3357.

USED MEDICAL EQUIPMENT. Complete suites or individual pieces bought and sold. Also examination tables, O.R. tables, O.R. lights, EKG's, therapeutic and diagnostic ultrasound, diathermy surgical instruments,

microscopes, etc. Please call or write Robert Shapiro at 2618 W. Peterson Avenue, Chicago, IL 60659; (312) 743-3900.

GENERAL INTERNIST. Invest in yourself! One suite remaining in new medical building with numerous specialties now represented. Located in university town in Dunes country of southern Lake Michigan, fifty miles from Chicago. Superior schools, many recreational opportunities, small town atmosphere. Join other physicians now in independent private practice. Achieve your optimum potential by beginning your own practice in this beautiful new building. Complete lab and x-ray. May invest in building or rental available with large subsidies for beginners. Three minutes from 400-bed hospital with all medical facilities. Contact: Thomas J. Covey, M.D.; (219) 462-4167.

FOR RENT: Medical/dental suite located in Hinsdale in prestigious professional building with elevator and spacious parking. 1200 square feet includes 6 rooms plus waiting room and business office. Excellent built-in cabinets, carpeting and tile; some furniture available. Lab, x-ray and pharmacy on premises. Available now at below market rate; (312) 325-6880.

MEDICAL OFFICES and suites available: Lincoln-Ashland-Belmont, Chicago, Illinois. 200-1200 square feet, professional building, elevator, full service janitorial staff, central heat & A/C. Gary Solomon & Co (312) 334-5400.

FOR SALE: ADR 4000 SL Ultrasound machine; price negotiable, Oak Park. (312) 383-9729.

FOR SALE—Family practice by board certified M.D. established 40 years; grossing $200,000 plus. Currently without O.B. with minor surgery. Limitless opportunity for young energetic physician. Town 50,000—15 miles east of St. Louis. Two hospitals supplying coverage in all specialties. Reply to Box #2057, c/o Illinois Medical Journal, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MORTON GROVE, 6000 west, just west of Edens. Affluent community. Move in condition, elevator building, 3 months free rent with lease. (312) 564-4050.

FLUOROSCOPIC PICKER X-RAY Machine, 12 years old, with automatic colimation and phototiming and upright Bucky with mirror image intensifier but no television. In excellent working condition. Please call (313) 358-3410, 9 a.m. to 5 p.m.

MEDICAL EQUIPMENT: two Hamilton exam tables, one Allyn exam table, two BP units (wall type), one Welch Allen wall mounted oto/ophthalmoscope. All excellent condition. $1200 for all. Call (312) 952-8787.

HEALTH CARE PERSONNEL Consulting, Inc., a division of The Health Care Group, specializes in valuation and sales. We have practices currently available in the following specialty areas: allergy, dermatology, family practice, internal medicine, ophthalmology, pediatrics, psychiatry, psychology, radiology and urgent care. For more information regarding selling or buying a medical practice, contact our brokerage division at The Health Care Group, 400 GSB Bldg., Bala Cynwyd, PA 19004; or call (215) 667-8630.

LIBERTYVILLE, IL AREA. Pediatric practice grossing approx. $170,000 can be purchased for $80,000. Excellent location. Staff would stay on with new owner. Seeing approx. 25 patients each day in office. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

WISCONSIN PHYSICIAN PRACTICES. In or near major metropolitan areas, these practice locations provide close proximity to a variety of recreational opportunities as well as desirable cultural and life-style amenities. Many are in or near university/college communities. Practices are thoroughly evaluated to result in 2-5 year debt retirement, often with probability for substantial revenue growth. Revenues up to $290,000. Medical buildings included. Call coverage available. Family practice: four locations. South central Wisconsin and Fox River Valley. Some suitable for general internists. Dermatology: Superb SE Wisconsin suburban location. Call: Gary Forston, Metropolitan Business Brokers, Professional Services Division: (414) 453-1111.

CHICAGO, WEST GRAND AVE. General practice. Owner anxious to retire. Grossing $45,000 on short schedule. Asking $25,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

PRACTICE FOR SALE: 63-year-old, second generation general practice; 1½ hour drive south of Chicago; on ground floor in two story building, for sale or rent. Office 12 rooms 2-3 physicians. Excellent accredited hospital 4 blocks away with all specialties. Reply to Box #2066, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL BUILDING and practice for sale. Chicago northwest side. Grossing $72,000 annually, includes office equipment, supplies, and pharmacy business. Relocating. Spanish speaking doctor will stay to introduce patients. Call (312) 907-2223—24 hours.

AVAILABLE SOLO FAMILY Practice, established. Physician retirement. Office in Belleville, IL, near St. Louis. Six figure gross and population base 45,000. Two progressive hospitals locally. Contact J. J. McCullough, M.D. 110 N. High St., Belleville, IL 62220.

FOR SALE: 12-year-old urology practice in metro east St. Louis area. Gross $240K average, drawing approximately 125,000. Four area hospitals, easy referrals and educational facilities in St. Louis. Plenty of recreational facilities. Suburban living. Reply to Box #2070, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MISCELLANEOUS

PHYSICIANS—EMC*EXPRESS,™ General Electric's electronic medical insurance claim delivery service, is now available. Fully computerized accounts receivable management. Office Resources (815) 664-2567.

MEDICAL PRACTICE SALES and appraisals. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004; (215) 667-8630.

DISCOUNT HOLTER SCANNING Services starting at $35.00. Spacelabs holter recorder (cassette) available from $1275.00. Cardionostic holter recorder (cassette) available from $995.00. Smallest and lightest holters update. Fast service (24-48 hrs turn over). Hookup kits starting at $4.95. Special introductory offer of three free tests with any purchase or lease of the recorder. Cardiologist overread available for $15.00. If interested call (301) 870-3626.

MEDICAL TRANSCRIPTION: Federal disability letters, consultations, progress notes; 24 hour toll-free phone-in dictation service; fast turn-around time; fee per line. Certified Medical Transcriptionists (AAMT), qualified in all specialties. Hagedorn Secretarial Service, Inc., "Specialists in medical transcription"; (312)296-0034.

MEDICAL PRACTICE SALES. At Medidentic we have the expertise and the contacts to sell your practice. Buyers and sellers, see our ad on page 397. Medidentic Practice Sales—(312) 696-0220.

WANTED EQUIPMENT for animal hospital. Good microscopes, CAT scan, ultra-sound instruments, defribillator autoclave. Herlihey Animal Hospital, 601 S. Rt. 83, Elmhurst, IL (312) 833-1332.

THINKING OF SELLING YOUR PRACTICE? We have cash buyers paying highest prices. Have your practice appraised by professionals. Call or write at no obligation. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

31st Annual Meeting

By Robin Bluestein, CMA-C

On April 25, 1987, Betty Burkhart, CMA, installed the 1987-88 officers of the Illinois Society of Medical Assistants at the Sheraton Inn in Normal, Illinois.

Cheryl Hutchison, CMA, of the St. Clair Chapter, was installed as president. Cheryl has been a member of the Illinois Society of Medical Assistants since 1976. She became certified in 1977 and revalidated her certification in 1982 (she is presently preparing to revalidate again). Cheryl's theme this year is "Growing Together" and she hopes to increase membership and unity, stressing the importance of this profession and our organization to the medical community and the public.

In addition, the following individuals were elected to office:
Mary Lu Ostrowski, CMA, immediate past president, McLean Chapter;
Robin Bluestein, CMA-C, president-elect, Northwest Cook Chapter;
Karen Schuerman, CMA, 1st vice president, McLean Chapter;
Rebecca Matteson, CMA, EMT, 2nd vice president, Spoon River Valley;
Marjorie Goldasich, recording secretary, LaSalle Chapter;
Carolyn Ott, CMA, corresponding secretary, McLean Chapter;
Linda Harp, CMA, membership secretary, St. Clair Chapter;
Mary Frances Burton, treasurer, Chicago Chapter;
Betty Kronemeyer, CMA, speaker of the house, St. Clair Chapter;
A. Ruth Thompson, CMA, vice speaker of the house, Macon Chapter;
Janet Binkowski, RN, chairman, board of trustees.

Appointed officers who will be working with Mrs. Hutchison this year are as follows:
Synobia Payne, parliamentary advisor, Chicago Chapter;
Betty Burkhart, CMA, chaplain, St. Clair Chapter; and
Julie Stoffregen, CMA, historian, Northwest Cook Chapter.

All officers were interviewed to determine their goals for the 1987-88 year. Interestingly enough, most answered similarly by stating their objectives were: (1) increasing membership (while retaining present members); (2) improving communication (both within our membership and between our members and the medical community as well as the public); and (3) to continue working towards quality educational programming for our members.

According to the American Association of Medical Assistants (AAMA), a medical assistant is a professional multi-skilled person dedicated to assisting in all aspects of medical practice under the supervision of a physician. This practitioner assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions. Competence in the field also requires that a medical assistant communicate effectively, adhere to ethical and legal standards of professional practice, recognize and respond to emergencies and demonstrate professional characteristics.

Information regarding the Illinois Society and/or medical assisting can be obtained from Cheryl Hutchison, CMA, president, Illinois Society, 53 Lockhaven, Granite City 62040. ◀

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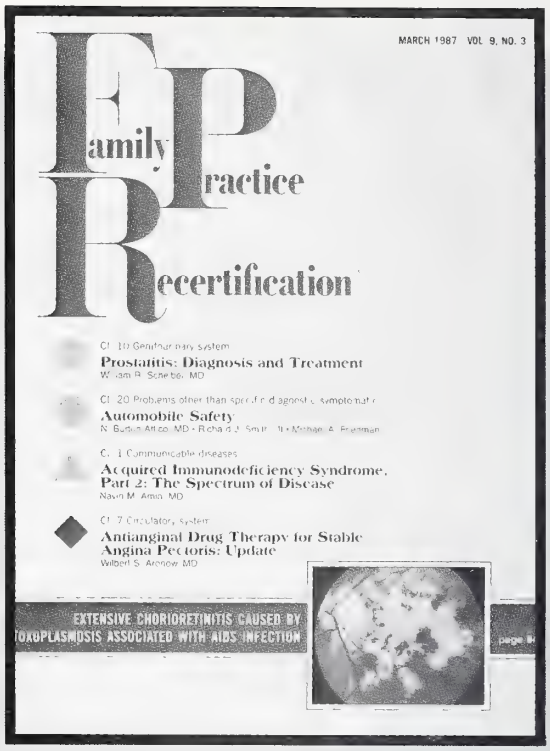
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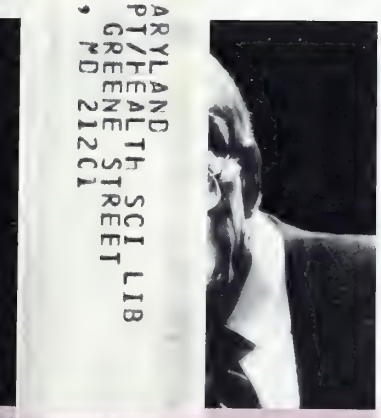
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Contributing to an Improved Community



Harry Truman once remarked while campaigning for re-election, "People criticize me for being a politician. Well, in this country, government is politics, and I'm glad I'm a good politician."

Government has deeply affected the practice and delivery of medical care in recent decades. Very few physicians come easily to politics, but I think we may have to re-examine our place in society and become better spokesmen and contributors to the political process. Certainly, the legal profession has recognized its place in the governmental process and in elective office.

Physicians, so closely involved with people and their problems, constantly cope with human realities and the effect of government programs such as Medicare, Social Security and mental health. Traditionally, we physicians take care of our patients' needs, perhaps enter community service as school board members or local leaders in civic projects, but generally avoid the "rough stuff" of politics. Very few physicians have ever worked a precinct.

If we see societal problems and inept solutions affecting the lives of our patients, we are obligated as physicians to respond. As government directs and intervenes more and more in our increasingly complex society, we will have to accept greater responsibility to provide information and guidance. Under the Hippocratic Oath, each physician promises to "practice my art . . . for the good of the sick . . . holding myself aloof from wrong, from corruption and vice."

Recently, medical liability problems have intruded into our professional lives, catching us unaware. Ten years ago it would have been hard to imagine the impact these issues would have in our lives. The medical malpractice crisis has accomplished something no other issue has done: it has politicized the average doctor. Every physician knows who his legislators are and where they stand on such concerns as caps, the statute of limitations and the insurance crisis.

We must continue to speak out on issues that affect our patients' lives and direct the expenditure of 12% of our Gross National Product. AIDS legislation, DRGs, COBRA and cost containment issues will demand increasing input from the medical community. We have to respond.

Speak out about these concerns. Be accurate with the facts. For example, only 25% of the Illinois State Legislature—House and Senate—consists of members of the legal profession. And they are not all members of the Illinois Trial Lawyers Association. So it is inaccurate to say that laws are made by lawyers.

Your unique position in the community as caregiver and civic leader makes your voice credible when you talk to service clubs, associations, and patients. Be sure your legislators are aware of the facts, and offer to be a source of information and help in preventing misperceptions about health-related issues. We must not allow others to see us as a group concerned only with pocketbook issues.

Your medical society stands ready to provide information and background material at all times. I remind you of the ISMS Code of Ethics, which concludes, "A physician shall recognize a responsibility to participate in activities contributing to an improved community."

Please contact ISMS headquarters at 312/782-1654 or 1-800/782-ISMS for assistance in planning community education activities. ◀

Edward J. Fesco, M.D.

Edward J. Fesco, M.D.
President

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by medical student Bradford W. Betz, Loyola University Stritch School of Medicine, Maywood.

A 67-year-old woman had worsening, noncolicky left upper and left lower quadrant abdominal pain of three days duration. She experienced nausea and vomiting but no change in bowel habits. Several brief episodes of similar but self-limited abdominal pain have occurred over the past several years.

The patient is afebrile. Her abdomen is mildly distended with left upper quadrant tenderness but no rebound. Laboratory studies are normal. Computed tomography and a barium enema are shown.

Figure 1
This barium enema shows medial displacement of the splenic flexure.



Figure 2
Computed tomography of the abdomen.

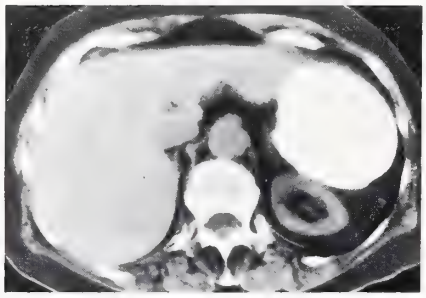


Figure 2A: Image of upper abdomen

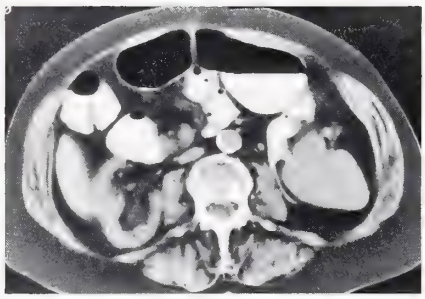
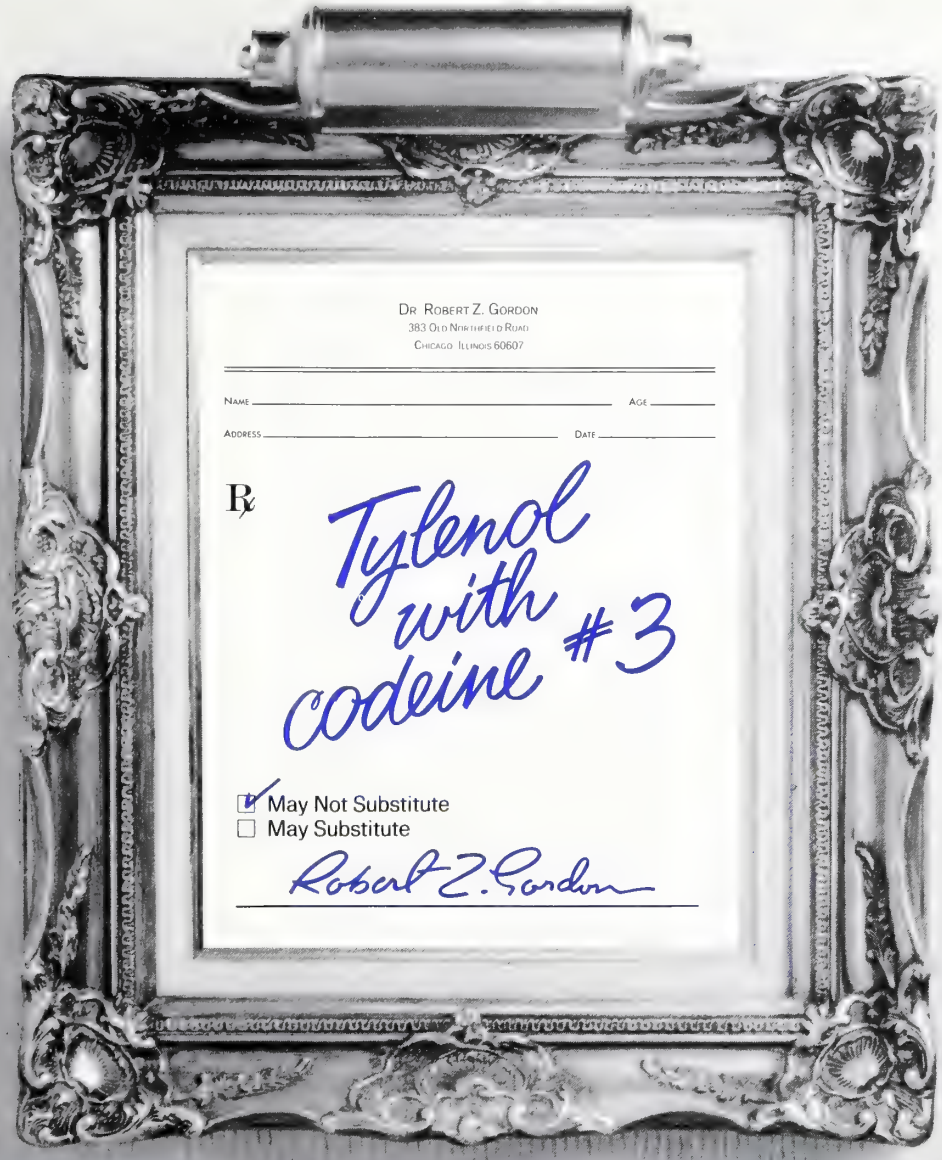


Figure 2B: Image of mid-abdomen

Your diagnosis?

1. Twisted hemorrhagic ovarian cyst
2. Renal mass
3. Wandering spleen
4. Abdominal abscess
5. Mesenteric cyst

(Continued on page 52)



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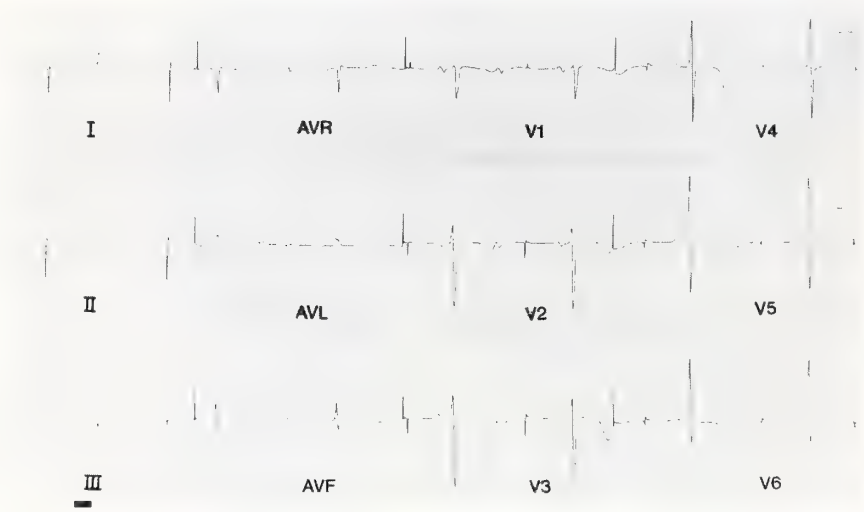
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was an eighty-year-old woman who had had a ventricular demand pacemaker inserted in 1978. The patient did well until one week prior to this admission. At that time she reported flu-like symptoms of cough and cold sensations. This developed into a progressive dyspnea on exertion. Later in the week, paroxsymal nocturnal dyspnea and pedal edema appeared. She denied chest pain, palpitations, or syncope. Her dyspnea on exertion worsened to the point where she could not walk two blocks. This woman had a forty-year history of hypertension and had undergone laser therapy for glaucoma. Medications included digoxin 0.125mg/day and furosemide 40mg/day.

Physical exam showed a blood pressure of 190/76mmHg and a pulse of 42 beats per minute. There were two centimeters of jugular venous distension at 30° Fowler's position. The lungs demonstrated decreased breath sounds and bilateral bibasilar crepitant rales. On examination of the heart there was an atrial (S4) and a ventricular gallop (S3), and a grade 3/6 systolic murmur at the base; there was 1+ pedal edema. Chest x-ray showed cardiomegaly, the pacemaker unit, bilateral pleural effusions and pulmonary vascular redistribution. This twelve lead ECG was obtained.

Questions:

1. **The twelve lead ECG shows:**
   A. Premature ventricular beats in bigeminy.
   B. An acute inferior wall myocardial infarction.
   C. Sinus rhythm with 2:1 atrioventricular (AV) block.
   D. Pacemaker failure to capture.
   E. Pacemaker failure to sense.

2. **Appropriate treatment measures in this patient could include:**
   A. Intravenous lidocaine.
   B. Oral procainamide.
   C. Increased dose of furosemide.
   D. Pacemaker replacement.
   E. Serial serum enzymes and ECGs to rule out a myocardial infarction.

(Continued on page 56)

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Referral Dilemmas

Restricted referral agreements contained in HMO and PPO contracts may increase your professional liability exposure and also your exposure for economic loss.

Suppose you have been referring your patients to the ABC Specialty Group for the past 10 years. Your patients have never had a problem there and you know the physicians practice good quality medicine. You sign a contract with the XYZ PPO, which requires you to refer patients only to PPO contract providers. But the ABC Medical Group did not sign a contract with the PPO. You may continue to refer your private patients to the group, but what about your PPO patients?

After examining the PPO specialist roster, you realize that you are not familiar with the particular specialist listed to meet your patient's current needs. If you refer your PPO patient to the ABC Group, you are probably violating your contract. If the PPO refuses to reimburse the patient for the noncontracting providers' fees, the patient may have a claim against you for economic loss. If you refer your patient to the PPO specialist you know nothing about, are you practicing good quality medicine?

You know your "standard of care" is the same for contract patients as for private patients. In essence, your duty to a patient is to possess and use the degree of care and skill ordinarily used by a reasonably well-qualified physician of your specialty when presented with similar facts. If, in treating your patient, you realize (as a reasonably well-qualified physician exercising ordinary skill and care should realize) that this patient's condition requires consultation or referral to a specialist, then it is your duty to refer the patient to, or consult with, a specialist. You should be familiar enough with the physicians to whom you refer patients to reasonably believe that they are qualified to handle the problem. If the physician to whom you refer provides substandard care *and* you should have known this or actually did know, then you may be liable for negligent referral. The fact that the specialist is affiliated with the PPO does not insulate you from liability.

The best way to avoid referral dilemmas is to do your research before you sign the contract. Contracts which require (or encourage) you to perform services which are outside the scope of your normal practice may conflict with your duty to refer patients to specialists. If the contract prohibits referrals to noncontracting providers, does it also specify that the PPO contract with an adequate number and variety of specialists? Is there an adequate number and variety currently under contract with the PPO?

The contract may permit referrals to noncontracting providers if you obtain prior authorization from the PPO medical director. If this is the case, do the standards used in granting or denying authorization conform to good medical practice? Are the authorization decisions made promptly? How frequently are referrals to noncontracting providers authorized? (See the March *IMJ* "Reading Between the Lines".)

If you refer a PPO patient to a noncontracting physician, hospital or facility, be sure that the patient understands that the provider is not under contract with the PPO *and* anticipates the accompanying economic consequences. The patient will most likely be liable for increased deductibles and copayments, and could incur a significant economic loss.

Because you're an informed physician, who recognizes the complex issues involved in contracts for the delivery of medical care, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the Office will provide you objective comments on any HMO, PPO or IPA contract at no cost. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the Office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

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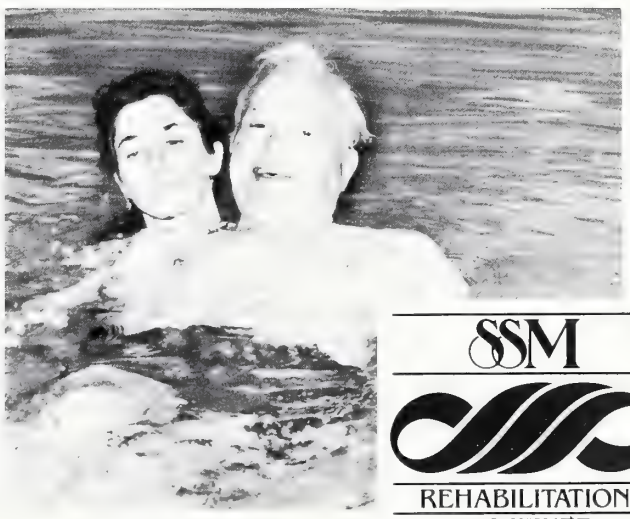
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ABSTRACTS OF ACTIONS

April 9, 1987 *Westin O'Hare Hotel*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

DRUG UTILIZATION REVIEW

ISMS representatives met with IDPA to discuss the potential implementation of a Drug Utilization Review (DUR) program for Illinois. The program was developed by Health Information Design, Inc. (HID), an Arlington, Virginia pharmaceutical research firm specializing in the development of model programs to target patients who may be at risk for pharmaceutically induced conditions.

The premise of the program is to identify IDPA recipients who are receiving potentially contraindicated pharmaceuticals from one or more physicians. Under the terms of the proposal, IDPA would contract both with HID to identify instances where contraindicated drug products have been prescribed for IDPA recipients and with ISMS to administer the program in Illinois. HID would use its computer capacity to review IDPA MMIS Drug Program data to identify where contraindicated prescriptions may be occurring.

HID would generate specific "alerts" to ISMS to indicate occurrences of possible drug product contraindications. The "alerts" are purely informational and in no way subject the physician to any punitive or regulatory review. The Board authorized the development of a specific Drug Utilization Review (DUR) proposal with IDPA and Health Information Design, Inc., (HID) for the Board's consideration at a subsequent meeting.

TORT REFORM LEGISLATION

The Board of Trustees discussed the status of the legislative climate in Springfield and approved the following bills for introduction: (1) $250,000 cap on noneconomic losses; and (2) statute of limitations for minors, with the following modification—that legal counsel draft an exemption in the statute for those latent or tardy disorders that would not demonstrate themselves within the confines of the reduced statute.

MEDICAL PRACTICE ACT

The Board reviewed proposed language being circulated by the Illinois State Bar Association regarding the corporate practice of medicine and agreed not to incorporate this in the ISMS draft of the Medical Practice Act, and it be vigorously opposed.

In addition, the Department of Registration and Education has recommended that medical licensure fees be established at $130 per year. The Board agreed that: (1) additional licensure fee negotiations were needed, with a maximum of $100 per year; (2) the fee for initial licensure be $300; (3) the fee for a three year temporary license be $100; and (4) the fee for license renewals for physicians outside of Illinois be $200. In addition, the Board agreed that ISMS, as part of the yearly appropriation process before the General Assembly, obtain assurance that general revenue funds are budgeted in support of the medical licensure and disciplinary processes.

EXEMPTION OF SURGICAL TISSUE FROM REVIEW

The IDPH Hospital Licensing Board has been asked to consider adopting rules to exempt certain types of tissues and materials from required examination, similar to what the Ambulatory Surgical Treatment Center Advisory Board has done. The Board agreed to support changes in the Hospital Licensing Act rules to permit a hospital to exempt certain tissues and materials removed during surgery from the required pathological review, using the Ambulatory Surgical Treatment Center Advisory rules as a model approach.

TRANSMISSION OF HTLV-III/LAV

The Board reviewed Resolution 35 (A-87) which calls on ISMS to endorse the Federal Centers for Disease Control recommendations for preventing the transmission of the AIDS virus in health facilities. The Board agreed to support these with the following addition: "That the ISMS Board of Trustees develop public position statements consistent with current medical data, and encourage physicians to educate their patients and communities pertaining to public health issues of preventing the transmission of AIDS in all population groups."

DRUGS AND THERAPEUTICS

The Board approved that the following drug prod-

(Continued on page 59)



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Today, most commercial professional liability insurers have abandoned the Illinois market. But there's still one company writing malpractice coverage up to $2 million per incident with a $4 million aggregate—the Illinois State Medical Inter-Insurance Exchange.

The Exchange is the only malpractice insurer in Illinois that is owned and operated by physicians. As such, we are totally committed to meeting the insurance needs of our policyholders. And we intend to be there as long as they need us.

Despite the recent explosion in medical malpractice litigation, the Exchange remains in good shape financially. Much of our success can be attributed to the willingness of the company's physician directors to make tough decisions—decisions like the switch to a "claims-made" policy form...the setting of adequate premium levels...and the strengthening of standards for renewing coverage and accepting new policyholders.

In the continually changing liability climate, the Exchange's directors will continue to make the sound business decisions necessary to ensure the company's long-term financial stability. But as physicians themselves, they also will be making those decisions from a policyholder's perspective. And that will translate into the best possible insurance coverage available, including...

...aggressive defense of frivolous claims;

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As a company owned and operated by physicians, the Exchange exists solely for the benefit of its policyholders. Some 9,000 physicians in Illinois are depending upon us. And we don't intend to let them down.

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Volume 172, No. 1
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Infant Sex Sequences

By Jason C. Birnholz, M.D.
and Elaine E. Farrell, M.D./Chicago

Conversation with multiparous pregnant patients during antenatal ultrasonic sexing,[1] produced the subjective impressions that either male or female children may predominate in small families, and there may also be a tendency in large families for sexes to occur in sequences. These possibilities appear to be included in the folklore of pregnancy expressed by our patients, but are not addressed explicitly in the technical literature. We decided to test these surmises statistically in a relatively small population sample. If these effects do occur with frequency, they might be important considerations in individual family counseling.

Sex sequence data on multiparous pregnant patients were ascertained through questionnaires provided our patients and colleagues. Information was sought on birth order and sex of children, the respondents' siblings and their partners. We limited data collection to single partnerships, assuming, but not seeking to confirm, consistent paternity. Liveborn infants or live fetuses and cases of fetal death *in uteri* were scored. Miscarriages or abortions were noted as a neutral when fetal sex was not known. Likewise, external sex was taken as the standard without further inquiry. No known cases of intersex, testicular feminization, ambiguous genitalia, Klinefelter's syndrome or Turner's syndrome were included.

None of the recently pregnant patients had been enrolled in any type of sex selection protocol. Each questionnaire requested the ethnic background of each parent. We encouraged responses from individuals with large family sizes. Birth order was assigned by a randomization procedure for the few cases with discordantly sexed twins.

Infant sex runs were evaluated with the Wald Wolfowitz test,[2] and a "run" length of 1,2,3, referring to sex transitions within a series. For example, a family listing of "MMFMFFF" has two runs of length 1, 1 run of length 2 and 1 of length 3.

Results

There were 15 questionnaires of three family groupings (73 white, 66 black, eight Hispanic, three Indian, and one Filipino), comprising a total of 1706 individuals.

Ratios of male to female children per birth order are shown in Table 1. There is a pronounced male preference for the first child. The M/F ratio for the entire population is 1.032, *i.e.*, 50.8% males and 49.2% females. Of 341 children of families with two or more offspring, percentage incidences of combinations were: MM 28.2, MF 26.4, FM 21.1, FF 24.3. Contingency tables for the sex of a third child, given possible combinations for the first two children, and for a fourth child, given all boys or girls for the first three, are shown in Table 2. Table 3 shows 98 families of six or more children with pooled runs and run lengths. We found no statistically evident trend toward sequential runs analyzed separately by family size for 5-13 children, either with sexes combined or by separate male-only

Table 1.
Sex Ratio By Birth Order
(See Table 4 for Comparisons)

Birth Order (Child #):	1	2	3	4	5	6	7	8	9	10
M	207	168	143	100	67	54	42	24	21	14
F	175	172	137	106	76	46	37	34	20	15
M/F	1.18	.99	1.05	.94	.88	1.17	1.14	.71	1.05	.93

Table 2
Contingency Tables for Sex Sequence for Families With Three or More Children

	M	F			M	F
MM	12	37	79	MMM	16	13
MF	36	34	70	FFF	12	11
FM	29	28	57			
FF	34	39	73			
	141	138	279			

Table 3
Runs and Run Lengths in 98 Families with Six or More Children

	1	2	3	4	5	6	7	8	Run Length
418F & 434M	249	114	67	20	10	4	3	—	467
434M	124	56	33	10	7	1	2	—	234
418F	125	58	34	10	3	3	1	—	233

or female-only series. There was no evident aggregation of miscarriages/abortions by birth order or sex composition of other siblings.

Discussion

There were some striking examples of "runs" within the data set, but no statistical indication that this phenomenon pertains to the general population using Wald-Wolfowitz criteria. No obvious clinical or ethnic features were noted in those cases where long runs occurred, and there was no consistent sex preference within those families. We applied the relatively straightforward Wald-Wolfowitz run length test, rather than more recently developed and presumably more sensitive nonlinear regression techniques, because we were interested in detecting a gross phenomenon suitable for patient counseling. In this same context, we presume that by combining data of first order relatives (*i.e.*, children plus both parents' siblings), we might have introduced a bias more likely to unmask a sex sequence selection process.

We observed the expected male excess[3,4] for the first child (Table 4), and found that the MM (and MMM) combinations were most frequent, and FM the least frequent. Nevertheless, these data do not indicate that one can make confident predictions of sex after the first pregnancy, even given an apparent "run" of boys or girls initially. This was clear from attempted analysis of runs for larger families. We presume also that observed fluctuations in M/F ratios for birth order 5-9 are sampling artifacts and/or statistical variations occurring in a small population sample. Lack of significant statistical association between sex ratio and birth order was noted in a large population survey from Japan.[5]

Significant departures from simple binomial distributions for infant sex have been noted in every large population survey,[6-9] although the pattern appears to vary either geographically or, possibly, by sampling era. In this last context, we presume the disproportionately high M/F ratio observed for the first child may reflect local trends in perinatal care with earlier, elective delivery of stressed infants, coupled with advances in neonatal infant medical care. Our sample probably carries an occult bias, as it includes patients referred for ultrasound studies because of "high risk" history.

Pickles, *et al.*, in their detailed statistical analyses of sex ratios in smaller families, identified four possible distributional mechanisms. These were (1) the "Markovian," in which the sex of successive children is linked; (2) the "Lexian," in which a few families within the full population tend to produce single-sexed offspring; (3) the "Poisson" in which sex ratio may depend upon birth order (or parity); and (4) the result of arbitrary family "stopping" rules,[10] such as continuing pregnancies until both sexes are achieved (Scotland),[9] or continuing until there is a male offspring (Korea).[11] They suggest that Lexian and family limitation mechanisms may be operative, but statistically discount Markovian or Poisson effects. They also note the likelihood that particular "stopping rules" vary within the population for individual families. Our own very limited sampling of larger families suggested that couples tending to produce a single sex with 75% or higher prevalence comprised less than 20% (27/145) of the families with five or more children, which is within statistical expectation for a binomial distribution.

Table 4
M/F Ratios by Birth Order Extracted from Selected Population Studies

Population	Birth Order (Child #) 1	2	3	4	5	6	7
US (white, 1968-71)[3]	1.064	1.058	1.057	1.052	1.042	1.044	1.038
US (black, 1969-71)[3]	1.040	1.029	1.016	1.019	1.007	1.012	1.006
US (1947-52)[4]	1.066	1.059	1.052	1.052	1.049	1.050	1.041
Finland (<1956)[6]	1.017	1.039	1.019	1.011	1.049	1.026	.991
Sweden[7]	1.082	1.082	1.083	.99	1.090	1.105	
Scotland[9]	1.062	1.041	1.033	1.193	.926		
India[8] (urban + rural)	1.251	1.032	1.047	1.027	1.031		

Conclusion

We conclude that there remains a "random" designation of infant

sex, with superimposed bias for males among liveborn children, at least at a nominative level for individual families. This conclusion was formed despite the subjective impressions we had formed in our clinical practices. ◀

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Elaine E. Farrell, M.D., is a neonatologist affiliated with the department of pediatrics, Evanston Hospital, Evanston, and an assistant professor of pediatrics at Northwestern University Medical School, Chicago. A graduate of the Harvard Medical School, Boston, Dr. Farrell is a fellow of the American Academy of Pediatrics and a past recipient of the National Institute of Health's National Service Research Award.

Jason C. Birnholz, M.D., is a board certified radiologist affiliated with Rush-Presbyterian-St. Luke's Medical Center, Chicago, in the departments of radiology and obstetrics and gynecology. Dr. Birnholz is a professor of radiology and assistant professor of obstetrics and gynecology at Rush Medical College, Chicago. He is a fellow of both the American College of Obstetrics and Gynecology and the American College of Radiology, and an advanced academic fellow of the James Picker Foundation.

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OBITUARIES

***Abelson, Stanley B.,** Vero Beach, Florida, died May 31, 1987 at the age of 78. Dr. Abelson was a 1937 graduate of the University of Health Sciences/Chicago Medical School.

****Barber, Harry C.,** Mesa, Arizona, died April 19, 1987 at the age of 83. Dr. Barber was a 1931 graduate of the Washington University School of Medicine, St. Louis.

****Canfield, Bruce H.,** Pompano Beach, Florida, died May 8, 1987 at the age of 79. Dr. Canfield was a 1934 graduate of the University of Minnesota Medical School, Minneapolis.

****Decker, Fred H.,** Peoria, died April 16, 1987 at the age of 88. Dr. Decker was a 1927 graduate of Rush Medical College, Chicago.

****Duffy, Joseph E.,** Joliet, died May 12, 1987 at the age of 82. Dr. Duffy was a 1928 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Ehrlich, Louis,** Kankakee, died November 6, 1986 at the age of 72. Dr. Ehrlich was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

***Ezdinli, Ediz Z.,** Kenilworth, died June 7, 1987 at the age of 59. Dr. Ezdinli was a 1955 graduate of the Facolta di Medicina e Chiurgia dell'Universita di Roma, Rome, Italy.

***Herath, William A.,** Moline, died May 19, 1987 at the age of 65. Dr. Herath was a 1945 graduate of the University of Illinois College of Medicine, Chicago.

***Kodelsky, Igor R.,** Chicago, died January 1, 1987 at the age of 68. Dr. Kodelsky was a 1947 graduate of the Medizinische Fakultat der Ludwig Maximiliams-Universitat, Munchen, Bayern, Germany.

****Manshardt, Donald O.,** Peoria, died April 20, 1987 at the age of 80. Dr. Manshardt was a 1935 graduate of Northwestern University Medical School, Chicago.

***Orloff, Mollie E.,** Atlanta, Georgia, died April 23, 1987 at the age of 79. Dr. Orloff was a 1931 graduate of the Medical College of Pennsylvania, Philadelphia.

****Rind, Rudla,** Santa Monica, California, died February 2, 1987 at the age of 88. Dr. Rind was a 1924 graduate of Rush Medical College, Chicago.

***Roth, David,** Deerfield, died June 4, 1987 at the age of 64. Dr. Roth was a 1956 graduate of the Boston University School of Medicine, Boston, Massachusetts.

***Siaroff, Sirano,** Kankakee, died December 25, 1986 at the age of 77. Dr. Siaroff was a 1945 graduate of the Medizinische Fakultat der Georg-August-Universitat, Gottingen, Niedersachsen, Germany.

***Suma, F. Nelson,** Rockford, died April 22, 1987 at the age of 61. Dr. Suma was a 1948 graduate of the University of Cincinnati College of Medicine, Cincinnati, Ohio.

***Sweeney, Anthony J.,** Palatine, died May 16, 1987 at the age of 71. Dr. Sweeney was a 1940 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Szczurek, Edward W.,** Chicago, died May 29, 1987 at the age of 75. Dr. Szczurek was a 1938 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Vaskevicius, Ona,** Chicago, died April 17, 1987 at the age of 75. Dr. Vaskevicius was a 1937 graduate of the Vytauta Didziojo Universiteto Medicinos Fakelteto, Kaunas, Lithuania.

***Wedral, Jerry W.,** Oak Park, died May 15, 1987 at the age of 76. Dr. Wedral was a 1938 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Zitnik, Ralph S.,** Evergreen Park, died May 28, 1987 at the age of 55. Dr. Zitnik was a 1957 graduate of the Loyola University Stritch School of Medicine, Maywood. ◀

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

1987 Annual Meeting House of Delegates

The ISMS House of Delegates met at the Westin O'Hare Hotel in Rosemont, April 10-12, 1987, and took the following actions. The official minutes of the House are on file at the Headquarters Office of the Illinois State Medical Society.

IMJ *interviewed newly inaugurated 1987-88 officers to seek their views on clinical and socioeconomic issues of the day. Capsules are interspersed through the Summary to acquaint the reader with the Society's new leadership. Special presentations are detailed through photographs and summarized in the "Highlights" section.*

Reference Committee on Amendments to Constitution and Bylaws and Organizational Affairs

18 (A-86) Not Adopted
(Report E)—Reduced Dues for Young Physicians
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Defeated this 1986 resolution which called upon the Society to: (1) Give serious consideration to reducing membership dues for physicians just out of training who are going into practice to 25% dues for the first year; 50% for the second year; and 75% for the third year; and (2) Introduce a similar resolution to the House of Delegates of the American Medical Association for similar action.

3 (A-87) Adopted
Indemnification
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Illinois State Medical Society amend its bylaws by the addition of Chapter XVI Indemnification.

11 (A-87) Adopted
ISMS Policy Titled "Direct Billing"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the policy statement titled "Direct Billing" be deleted from the ISMS policy manual.

13 (A-87) Adopted
Amendment to Chapter VII, Section 1 and Chapter IX, Section 8A of the ISMS Bylaws
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that Chapter VII. The Board of Trustees and Chapter IX. Committees, of the Illinois State Medical Society Bylaws, be amended to include ". . .and the Chairman of the Board of Directors of the Illinois State Medical Insurance Services shall sit as *ex-officio* members. . ."

14 (A-87) Adopted
IFMC Bankruptcy
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the ISMS amend its: (1) Bylaws, Chapter VII, Section 2A., by deletion of the reference to IFMC; and (2) Policy manual by deletion of the item entitled, "Foundations for Medical Care," as well as any other references in the policy manual.

38 (A-87) Adopted As Amended
"Summary Suspensions" by County Medical Societies
Introduced by Raymond E. Hoffmann, M.D., Delegate for the Winnebago County Medical Society

Directed that the Society: (1) Recommend to its component county medical societies that they consider amending their bylaws to facilitate "Summary Suspensions" while at the same time appropriately guaranteeing due process to their members; and (2) Provide to component

medical societies information to assist them in updating their bylaws on a regular basis.

Substitute 47 (A-87) Adopted
Responsibility of the "AM News"
Introduced by Wayne N. Leimbach, M.D., Delegate for the Kane County Medical Society

Directed that: (1) The leadership of ISMS be directed to enter into discussions with the leadership of the AMA to establish policy that the "AM News" shall consult with and acknowledge the concerns of the State and local component societies before publishing articles that may have significant state or local implications; and (2) Pending the results of such dialogue we direct the ISMS delegates to the AMA to draft such resolution as to move the AMA to establish such policy that the "AM News" shall consult with and acknowledge concerns of state and local component societies before publishing articles that may have significant state or local political implications.

Reports
Filed for information the following reports:

President, President-Elect, First Vice-President, Second Vice-President, Secretary-Treasurer, 1986 Dues by County, Chairman, Board of Trustees, Trustees, Executive Administrator, Illinois State Medical Insurance Services, Inc., Illinois Delegation to the AMA, Committee on Insurance, Committee on Constitution and Bylaws, Policy Committee, Judicial Council, Planning and Priorities Committee, Publications Committee, Task Force on Financial Aid to Medical Students, Medical Student Loan Fund.

Reference Committee A

1 (A-87) Adopted
Physicians Liens



Morgan Meyer, M.D., ISMS past president and former AMA delegation chairman, (left) accepts a plaque from Robert C. Hamilton, M.D., chairman of the ISMS delegation to the American Medical Association.

Introduced by Pedro A. Poma, M.D., Chairman, Cook County Delegation

Directed that the Society develop and cause to be introduced legislation that would protect physicians more fully under the Illinois Physicians Lien mechanism by providing that issuers of Physicians Liens be formally notified when: (a) A Lawsuit is abandoned by the plaintiff attorney named on and served with the physicians lien; or (b) A lawsuit is lost by the plaintiff attorney named on and served with the physicians lien: or (c) The plaintiff discharges the attorney who has been named on and served with the physicians lien.

4 (A-87) Adopted
ISMS Policy Titled, "Medical Testimony. Expert Witnesses"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the the ISMS policy titled "Medical Testimony, Expert Witnesses" be revised to read as follows:

An expert witness is defined as a physician licensed to practice medicine in all its branches, having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, relevant personal experience, practical familiarity and technical knowledge of the problems that are being considered, as well as knowledge of alternative forms of treatment, and was active in the practice of the medical subject under discussion at the time the incident occurred.

17 (A-87) Adopted As Amended
Withdrawing or Withholding Life-Prolonging Treatment
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Adopted the following policy on withholding or withdrawing life-prolonging treatment:

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his/her family or legal representative (if the patient is incompetent to act in his/her own behalf) should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient, whose death is imminent, to die.

In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act on his/her own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent, but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times the dignity of the patient should be maintained.

19 (A-87) Adopted As Amended
Confidentiality and Utilization Review
Introduced by Pedro A. Poma, M.D., Chairman, Cook County Delegation

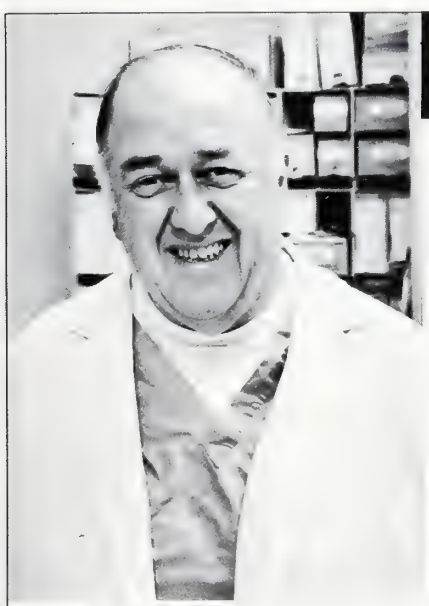
Directed that the following be the policy of the Illinois State Medical Society:

In order to protect patient care and confidentiality, physicians in Illinois should use judicious restraint when discussing any patient's care over the telephone.

That the Illinois State Medical Society establish objection to utilization review performed solely upon the basis of admitting diagnosis without actual hospital record review as being inadequate, incomplete and incapable of accuracy.

Physicians in Illinois who receive patient permission for a case discussion by telephone from their patients on behalf of third party payors may, ethically and in their own best judgment, make a determination as to whether a reasonable charge for their time and expertise in providing such telephone case review discussions should be made, if any, for these medical services.

In addition, the House directed that: (1) The Society bring this position to the attention of appropriate organizations; and (2) A similar resolution be brought before the next meet-



Clinical Concerns Must Come First

Edward J. Fesco, M.D. was elected ISMS' first vice-president at the Society's Annual Meeting in April. He assumed the post of president upon the untimely death of Dr. Allan Goslin three weeks after the meeting. A board certified general surgeon practicing in LaSalle, Dr. Fesco, who holds a master's degree in anatomy, received his medical degree from Northwestern University Medical School.

Dr. Fesco is particularly concerned about the increasing intrusion of government and other third parties into the practice of medicine.

"Of all the changes in recent years, the biggest impact on the delivery of medical care to patients is the difficulty the doctor has in evaluating sick people while trying to meet DRG standards and other mandates about admissions to hospitals. It interferes with a doctor's clinical reactions learned in years of practice and medical school. The doctor is torn between the things he knows he should do and what he has to do to keep government happy.

"We know sick people. And we know how to take care of them. But we're going to have to be able to convince those who control the money—especially federal and state governments, but also private corporations and self-insured industries which are putting limits on medicine—that clinical concerns must come first."

ing of the American Medical Association.

22 (A-87) Adopted
Policy Statement on "Veterans Administration"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the ISMS policy titled "Veterans Administration," should be deleted from the policy manual.

26 (A-87) Not Adopted
Mandatory Reporting for Lawyers
Introduced by Chester C. Danehower, M.D., for the Peoria Medical Society

Defeated this resolution which called upon the Society to encourage the: (1) Proper agencies of the state and the legal profession to institute a mandatory reporting system for attorneys which would cause to be reported and examined all cases of failed or unsuccessful litigation for the purpose of determining patterns of frivolous or incompetently pursued suits; (2) Supreme Court to place special emphasis on the responsibility of the courts to call attention to cases which are pursued in spite of their lack of merit or proper professional development; and (3) Attorney Registration and Disciplinary Commission to establish a special mechanism to evaluate all such reports for possible disciplinary action where indicated.

27 (A-87) Not Adopted
Malpractice Liability and Indigent Patients
Introduced by Luis E. Cespedes, M.D., Delegate for the DuPage County Medical Society

Defeated this resolution which called upon the Society to initiate legislative changes so that a physician who cares for indigent patients at no charge to either the patient or any other agency, should have protection from professional liability from these patients.



John J. Ring, M.D., Mundelein, current vice-chairman of the AMA Board of Trustees and a former member of the ISMS House and Board, addresses the House. Dr. Ring told the delegates that his visit was "like coming home." His comments addressed professional freedom and solidarity.



Dr. Jack Pickleman, a professor of surgery at Loyola University Stritch School of Medicine and chief of the School's division of general surgery, (R) accepts the 1987 Edwin S. Hamilton Interstate Teaching Award, presented by Fred Z. White, M.D., for the Illinois Council of Medical School Deans. The award, bestowed every three years upon an Illinois physician who distinguishes himself as a teacher, is sponsored by the Interstate Postgraduate Medical Association of North America.

32 (A-87) Adopted As Amended
Illinois Workers' Compensation Act
Introduced by L. Trupin, M.D., H. Failor, M.D., D. Morse, M.D., for the Champaign County Medical Society

Directed that the Society cause legislation to be introduced that would amend the Illinois Workers' Compensation Act to permit physician liens in workers' compensation cases.

36 (A-87) Referred to Board for Study
Medical Studies Act
Introduced by William E. Kobler, M.D., Delegate for the Winnebago County Medical Society

Referred to the Board of Trustees for study a proposal that the Society cause to be introduced and support legislation to include Medical Corporations and Medical Clinics under the provisions of the Medical Studies Act.

Reports
Filed for information the following reports:

Committee on Health Planning, Govermental Affairs Council, Medical Legal Council, Illinois Department of Registration and Education.

Reference Committee B

8 (A-86) Adopted
(BOT Report B)—Policy Statement on Governmentally-Supported Health Facilities
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the following policy statement be deleted from the ISMS Policy Manual: "ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine."

Substitute 14 (A-86) Adopted
(BOT Report C)—Application of Input-Output Economics to Health Care
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society ask the American Medical Association to undertake a study of the application of input-output economics to health care and report back to the House of Delegates.

16 (A-86) Adopted
(BOT Report D)—Honesty in Offering an HMO
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the ISMS Board of Trustees cause to be introduced legislation in the General Assembly to mandate employers to give employees a choice between private insurance and an HMO, and to forbid employers to offer only HMOs and not private insurance policies.

29 (A-86) Not Adopted
(BOT Report F)—Addressing the Health Insurance Needs of the Short-Term Unemployed and Those Persons "Medically Uninsurable"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Defeated this resolution which called upon the Society, in concurrence with the AMA, to investigate the establishment of a state-wide program to provide health insurance for the short-term employed; and that following such study, if indicated, the Society seek to enact legislation establishing a state risk-pooling program to ensure that adequate health insurance coverage is available at an affordable cost for those who would otherwise be unable to obtain such coverage because of medical consideration.

2 (A-87) Not Adopted
Medicare Changes
Introduced by Erlo Roth, M.D., Delegate for the DuPage County Medical Society

Defeated this resolution which called upon ISMS to urge the AMA House to sponsor and support legislation seeking the following changes in the Medicare law. That: (1) The health insurance of the elderly be transferred to the private sector, requiring health insurers to make coverage available to persons of all ages, regardless of previous medical history; (2) Medicare benefits be limited to subsidizing the cost of



To Iron Out Differences and Hammer Out Compromises

Alfred J. Kiessel, M.D., a board certified anatomic and clinical pathologist from Decatur, is serving his second term as chairman of the Illinois State Medical Society Board of Trustees. An ISMS trustee since 1976, Dr. Kiessel also serves as a member of the ISMS delegation to the American Medical Association. He has served as secretary-treasurer of ISMS, as chairman of the finance and policy committees and as a member of the board of directors for the Illinois State Medical Inter-Insurance Exchange.

Dr. Kiessel attended medical school at the University of Michigan and later served as president of both the Macon County Medical Society and the Illinois Society of Pathologists. He has been director of pathology at St. Mary's Hospital in Decatur since 1977, has served on the East Central Illinois Health Systems Agency Board, and was a founding board member of Decatur's Community Health Improvement Council. Dr. Kiessel also has been a member of two Illinois Department of Public Health advisory committees: one on clinical laboratories and blood banks and another on lead poisoning.

"One of the problems facing health care is the fragmentation of services and how it affects patient confidence in the system," Dr. Kiessel told *IMJ*. "Another major problem is the lack of resources committed to research and education of the practicing physician. A greater percentage of resources is devoted to research in developing countries than in the U.S. And there is a terrible decline in the number of autopsies.

"Organized medicine is more than a forum to discuss these issues. It's an opportunity to iron out differences and hammer out compromises so that physicians, as individuals, can present a united front.

"Organized medicine also ought to represent the public by helping to determine allocation of resources to patient care and clinical and basic research." ◀

health insurance for the elderly based on their ability to pay: and (3) Any citizen who, because of adequacy of financial resources, does not receive subsidized health insurance from Medicare, be exempt from any Peer Review Organization restrictions or any other Medicare utilization restrictions and have the freedom to receive whatever quantity and quality of services he is willing to pay for.



ISMS Public Affairs Breakfast speaker, State Representative Alfred G. Ronan (D-Chicago).

8 (A-87) Adopted
Dual Standard of Care
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society delete the statement titled "Dual Standard of Care" from the ISMS policy manual.

10 (A-87) Adopted
ISMS Policy Statement Titled "Reimbursement"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society delete the statement titled "Reimbursement" from the ISMS policy manual.



ISMS past Presidents gather for their annual gourmet dinner. Seated (L-R) are Leo P.A. Sweeney, M.D., Immediate Past President Morgan M. Meyer, M.D. and Robert C. Hamilton, M.D. Standing (L-R) are Robert P. Johnson, M.D., Frank J. Jirka, Jr., M.D., Joseph H. Skom, M.D., George T. Wilkins, Jr., M.D., P. John Seward, M.D., J.M. Ingalls, M.D., Fred Z. White, M.D., Cyril C. Wiggishoff, M.D., David S. Fox, M.D., Willard C. Scrivner, M.D. and Herschel Browns, M.D.

18 (A-87) Adopted As Amended
Channeling
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society encourage ISMIE to continue its study on how the concept of channeling might be appropriately applied to the Illinois professional liability market and report back to the House of Delegates.

24 (A-87) Adopted in Lieu of 28,30,31,51,53 (A-87)
PRO Review and Federal Law
Introduced by Thomas Stoffel, M.D., Delegate for the Rock Island County Medical Society

Directed that the Society: (1) Provide educational information to our members of Congress about the deleterious effects of the laws they have passed regarding PROs and seek to have them amended: and (2) Support the AMA's efforts in countering the deleterious effect of the laws regarding PROs.

Substitute 34 (A-87) Adopted
Rural Hospitals
Introduced by Carlos B. Lara, M.D., Delegate for the Pike County Medical Society

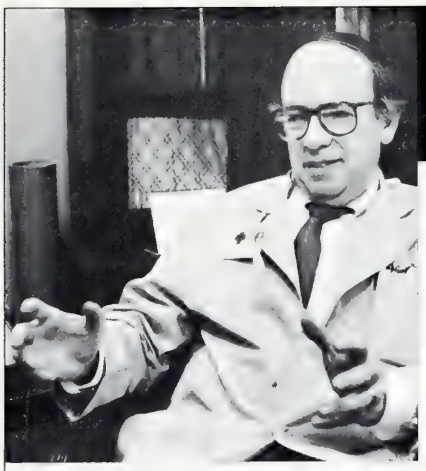
Directed that the ISMS Delegation to the AMA communicate the Society's concerns about the DRG payment differentials between urban and rural hospitals and urge an expeditious completion of the AMA's ongoing study.

41 (A-87) Adopted As Amended
Physician DRG Payments
Introduced by Jaime Cercone, M.D., Delegate for the Fulton County Medical Society

Directed that the Society: (1) Oppose physician DRGs; and (2) Communicate to the AMA its opposition to physician DRGs.

Reports
Filed for information the following reports:

Committee on Third Party Payment Processes, Council on Economics.



AIDS Epidemic Is Most Pressing Clinical Issue

A board certified plastic surgeon practicing in Evanston, Dr. Harry A. Springer will begin his term as president at the Society's 1988 annual meeting. Dr. Springer, a member of the ISMS Board of Trustees since 1983, has served as ISMS' first vice-president and second vice-president. A member of the ISMS delegation to the AMA, he is a past president of the Chicago Medical Society and a former member of that society's Board of Trustees. After receiving a Doctor of Dental Surgery degree from Northwestern University, he completed his medical education at the University of Texas at Dallas. Dr. Springer completed his internship and residencies at Cook County Hospital and Northwestern University Medical Center in Chicago.

Dr. Springer cites the current AIDS epidemic as the most serious clinical issue facing the medical profession today.

"AIDS is scaring both the patient and the physician," Dr. Springer told *IMJ*. "It's analogous to the syphilis epidemic of the Middle Ages, except that we have more tools to work with. I think we're facing something of similar proportions.

"Many people have been affected. Physicians and dentists have been impacted tremendously. AIDS affects all areas of practice, particularly trauma surgery. If I'm called upon to care for a trauma patient with facial fracture, I wear gloves. I can double glove, but that doesn't protect against wire puncture.

"AIDS is a tremendous challenge for medicine today. Our task is to work together as clinicians and colleagues to harness technology and expertise for our patients' well being."

Reference Committee C

Substitute 1 (A-86) Adopted
(BOT Report A)—Corporal Punishment in Illinois Schools
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society, as a policy, shall oppose child abuse of students in Illinois schools.

Report H Adopted in Lieu of 36 (A-86)
(BOT Report H)—Medical Staff Bylaws for Outpatient Surgical Centers
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that in lieu of Resolution 36 (A-86) the Society send all Ambulatory Surgical Treatment Centers a copy of the ISMS brochure, "A Physician's Guide to Due Process."

5 (A-87) Adopted
Medical Control in Pre-Hospital Care
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society adopt the following policy positions regarding medical control in prehospital care when a physician and paramedics are present: (1) All EMS systems should develop protocols which provide for cooperation between a physician on the scene of an emergency and paramedics responding to the emergency call; (2) It is the obligation of the physician who happens upon the scene of a medical emergency to provide reasonable identification to paramedic personnel that he/she is a physician and, if appropriate, has training in emergency procedures. If the paramedics are not in uniform, they should provide identification to the physician that they are certified by the state to provide emergency medical care; (3) When paramedics are present, a physician should avoid involvement in resuscitation measures that exceed his or her prior training or experience; (4) Where voice communication with the medical control facility is available, the paramedics and the physician on the scene should interact with the local medical control authority; (5) Where voice communication is not available, the physician on the scene of an emergency should cooperate with and abide by the EMS protocols, and per-

mit the paramedic team to function within their guidelines and the EMS law; and (6) In a non-emergency situation, where the EMS system provides the only available ambulance service in an area, a private physician and the medical director of the EMS system should make every effort to cooperate in the treatment and transportation of the patient, either through written protocols or voice contact, prior to requesting the ambulance service.

6 (A-87) Adopted As Amended
ISMS Policy Statement Titled "Mental Health"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Amended the ISMS Policy on "Mental Health" as follows:

MENTAL HEALTH

A. The Importance of Mental Health Education and Services

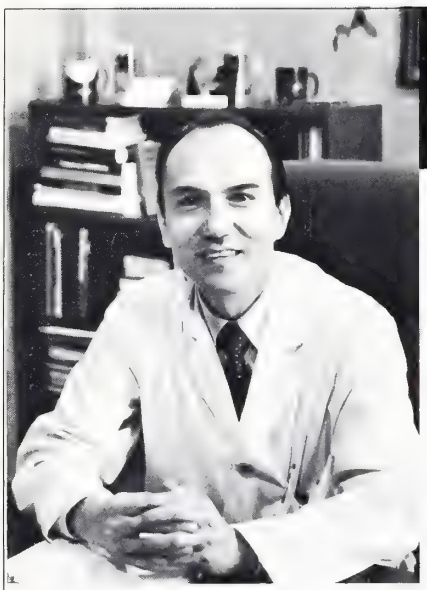
ISMS recognizes the importance of mental health in the quality of a person's life and the devastating impact mental illness can have for an individual and one's family. Knowing that modern medicine has much to offer, ISMS supports the training of physicians in mental health care, the education of the public in recognizing mental illness and the development of private and public services for care.

B. The Physician's Role in Mental Health Services

ISMS recognizes the primacy of the physician in the diagnosis and treatment of mental illness. Involuntary psychiatric hospital certification of any patient must, without exception, involve a physician licensed to practice medicine in all its branches. However, the discharge of any patient from a psychiatric institution must remain the responsibility of a physician.

C. Continuing Medical Education for Department of Mental Health and Developmental Disabilities Physicians

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating funds necessary to provide high-quality continuing medical education



Concern with the Issues of the Community

Dr. Pedro A. Poma assumed the post of first vice-president upon Dr. Fesco's elevation to president. (Dr. Poma had been elected second vice-president at the ISMS annual meeting.) An obstetrician-gynecologist practicing in Melrose Park, he is former chairman of the Department of Obstetrics and Gynecology at Gottlieb Memorial Hospital. Dr. Poma is a past president of the Chicago Medical Society. He has been a member of the ISMS Board of Trustees since 1983, and is a current member of the ISMS delegation to the American Medical Association.

After receiving his medical education at San Marcos University, San Fernando Medical School, Lima, Peru, Dr. Poma took residency training at San Marcos and Cook County hospitals. He also studied OBGYN pathology at Northwestern University.

Dr. Poma points to the quality of medical care as an issue that should command the profession's attention.

"Quality of care is a difficult issue to measure and to manage," Dr. Poma told *IMJ*. "I think the Society has been vigilant and has encouraged quality care through many different avenues. And it is our obligation as professionals to be sure disincentives, restrictions, or constrictions will not prevent us from delivering the best care possible.

"I think all physicians should work to improve themselves in their daily practices. I think we have to be more gentle, more attentive and more sensitive to the needs of our patients. And organized medicine should work to show the profession's concern not only with the personal issues of the physician, but also the issues of the community.



Impac Chairman George T. Wilkins, Jr., M.D., reports a good year and urges members to join. Total membership reached 5,390 at year-end 1986.

relevant to the needs of these physicians.

D. Cooperation between County Medical Societies and DMHDD

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to the state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available area-wide.

E. Patient Visits

The number of times a patient is seen should not be the sole criterion of the necessity or adequacy of psychiatric care. The level of care needed by the patient must be a major factor in determining the delivery of that care. Each hospital or hospital system should establish its own standard of psychiatric care to include the level of care needed by that patient, and should monitor the adequacy of psychiatric care by means other than frequency of visits.

F. Community Mental Health Services

ISMS supports and encourages the development of community options for services to the chronically mentally ill in the private and public sectors, though the society opposes using such alternatives to inappropriately discharge these persons to inadequate services and living conditions, thereby increasing the number of homeless mentally ill.

9 (A-87) Adopted
ISMS Policy Statement "Emergency Medical Care, Provision of"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the first paragraph of the policy statement titled "Emergency Medical Care, Provision of," be amended to read as follows: Emergency care should be provided to all patients, based only on medical necessity. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

Substitute 21 (A-87) Adopted
Policy Statement on "Eyes"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the ISMS policy titled, "Eyes," be retitled and amended as follows:

EYE CARE

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or administer eye medication for therapeutic purposes and services. ISMS vigorously opposes any legislative attempt in Illinois to allow non-physicians to prescribe or use medications other than approved topical agents used for diagnosis.



ISMS President Jere E. Freidheim (L) presents plaque to Dr. Earl Stockdale, recognizing his efforts to ensure immunizations for children in the Rock Island area and to organize a physician referral system offering free care for indigent patients. Dr. Stockdale helped Rock Island city schools achieve a 99% compliance level with respect to state laws regarding immunizations. In addition, more than $2 million in free medical care has been rendered to those in need through the physician referral program.

Substitute 33 (A-87) Adopted As Amended
School-Based Health Care
Introduced by Lynn Malanfant, Dele-

gate for the Medical Student Section

Directed that the Society: (1) Support the concept of local Boards of Education establishing school based programs or clinics, as appropriate, that may provide health and sex education, counseling and access to physical and mental health care services, as determined by the community



(L-R) Illinois State Medical Society Auxiliary President Mrs. Alex J. Spadoni, Dr. Alex Spadoni and ISMS House of Delegates Speaker Lawrence L. Hirsch, M.D. Dr. Hirsch introduced Mrs. Spadoni, who presented ISMS and ISMS Auxiliary contributions to AMA-ERF to provide financial aid for Illinois medical students. Nearly $134,000 was presented to AMA-ERF, with an additional $24,000 earmarked for the Illinois student loan fund. The medical student loan fund raffle winner, Bruce Becker, M.D., received a personal computer as the first prize award. In her report to the House, Mrs. Spadoni outlined the Auxiliary's activities in teen suicide prevention, health programs for the elderly, drug and alcohol abuse education, mammogram screening, fund raising and political involvement.

where the clinic exists. Local physicians should become involved in planning and delivery of those services; and (2) Forward a similar resolution to the AMA House of Delegates for consideration at its 1987 Annual Meeting.

35 (A-87) Adopted in Lieu of 35 & 45 (A-87)

Transmission of HTLV-III/LAV

Introduced by Janis Orlowski, M.D., Delegate for the Resident Physicians Section

Directed that the ISMS: (1) Board of Trustees develop public position statements and encourage physicians to educate their patients and communities, consistent with current medical data, pertaining to public health issues of preventing the transmission of AIDS in all population groups; and (2) Release an AIDS Alert to all Illinois media encouraging the people of Illinois to institute preventive education programs designed to reach all segments of society with particular emphasis on teens and young adults.

Substitute 39 (A-87) Adopted As Amended

NBME Examinations

Introduced by Lynn Malanfant, Delegate for the Medical Student Section

Directed that the Society inform Illinois residency program directors that the NBME examination is of limited scope and may not reflect the true abilities of an applicant, and therefore, it should not be the major criterion for screening.

Substitute 42 (A-87) Adopted As Amended

Hepatitis B Vaccination

Introduced by Lynn Malanfant, Delegate for the Medical Student Section

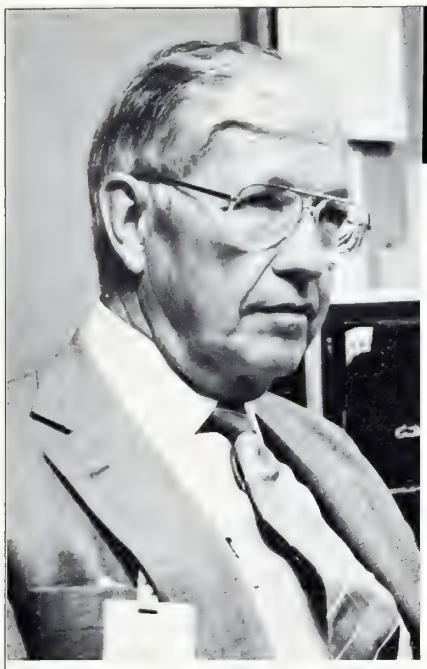
Directed that the Society: (1) Encourage medical schools to implement a program for hepatitis B vaccinations for students prior to their clinical training, with a minimum of financial barriers; and (2) Urge Illinois medical schools to have their financial aid offices recognize the cost of hepatitis B vaccination as a necessary expense in obtaining a medical education.

Substitute 43 (A-87) Adopted As Amended

Over-the-Counter Nonsteroidal Anti-Inflammatory Drugs

Introduced by Janis Orlowski, M.D., Delegate for the Resident Physicians Section

Directed that: (1) The Society request the AMA to encourage drug manufacturers to place precautionary warnings for all ages, especially the elderly, on packages of over-the-counter aspirin and other nonsteroidal anti-inflammatory drugs; (2) The warning specifically indicate that all patients, especially elderly patients, should consult their physicians before using the drug on an extended basis; and (3) The warning also indicate that all users discontinue the medication



No More Slack in the System

Dr. Harold L. Jensen of Flossmoor was re-elected to another term as ISMS secretary-treasurer at the annual meeting in April. A specialist in internal medicine, Dr. Jensen formerly served as an ISMS trustee and president of the Chicago Medical Society. An ISMS delegate to the AMA, he is a graduate of the University of Illinois College of Medicine, and has special training in quality assurance, utilization review, and continuing medical education. A clinical assistant professor of medicine at the University of Illinois Abraham Lincoln School of Medicine, he is a former medical staff president and department chairman at Ingalls Memorial Hospital.

Dr. Jensen believes that adequate access to medical care and tort reform are primary issues that should be of concern to physicians and their state medical society.

"We have a large segment of our population that does not have access to medical care," Dr. Jensen told *IMJ*. "The layers of government—state and federal—which ordinarily have taken responsibility for care have tried to get out from under their responsibilities. In the past, cost shifting by physicians and hospitals has been able to take up the slack. But we're running into a problem: there's no more slack in the system.

"Also, tort reform—not just medical tort reform, but tort reform generally—is a societal imperative that we're going to have to face up to.

"We're on the high moral ground on these issues. Our strength is the fact that we're patient advocates. We have to maintain that position, but it's being weakened by the HMO and the IPA situation where physicians are getting paid to avoid certain tests and provide less care.

"We have to fight those pernicious effects. We can't say that HMOs are bad or IPAs are bad because they're an honest attempt to pare down some of the fat in the economic medical system. But we're going to have take some kind of a position to monitor the effect they have on patient care."

and consult their physicians immediately if abdominal pain develops while taking the drug.

44 (A-87) Adopted As Amended
Medical Student Certification in Basic Life Support
Introduced by Lynn Malanfant, Delegate for the Medical Student Section

Directed that the Society ask the AMA to encourage the Liaison Committee for Medical Education (LCME) to recommend Basic Life Support certification and annual recertification, according to American Health Association or American Red Cross guidelines, of medical students enrolled in LCME accredited medical schools.

48 (A-87) Adopted As Amended
School Immunizations and Physicals
Introduced by Janis Orlowski, M.D., Delegate for the Resident Physicians Section

Directed that the Society support the concept of increased government funding for immunizations of school children.

50 (A-87) Adopted As Amended
Breast Reconstruction
Introduced by Pedro A. Poma, M.D., Chairman, Cook County Delegation

Directed that the Society support surgical modification of the second breast as a part of the staged reconstruction of the breast following mastectomy in whom it is medically indicated.

Reports
Filed for information the following reports:

Council on Mental Health and Addiction, Council on Medical Services, Committee on Drugs and Therapeutics, Council on Education and Manpower, Committee on CME Accreditation, Committee for the Impaired Physician, Physician Support

Getting Back To Why We Went Into Medicine in the First Place



A board certified ophthalmologist, Dr. Robert M. Reardon of Bloomington has served as an ISMS trustee and vice-speaker of the Society's policy-making House of Delegates. Dr Reardon is vice president of the board of trustees for Illinois Wesleyan University, where he is former secretary and also chairman of the Academic Affairs Committee. A member of the ISMS delegation to the AMA, he is a past president of the McLean County Medical Society who received his medical degree from the State University of New York Downstate College of Medicine, Brooklyn.

Dr. Reardon emphasizes that physicians must be able to look beyond their customary role as medical practitioner if they are to successfully face the issues confronting them and their patients.

"We're forever tied to the politicians," Dr. Reardon told *IMJ*. "As soon as Medicare came into existence, we were part of the political process. And we have to educate the politicians. I think for the most part, the politicians want help and they respect our role, but we've got to assume that role.

"We have the same constituency in a sense. They call them voters, and we call them patients. But they are the same constituency, and we both, ideally, want to represent them.

"These are very difficult times. But they are exciting times. And I think if we remember that our traditional role is that of patient advocate, then we're getting back to why we went into medicine in the first place. We've got to learn some new skills that we never learned in medical school—such as how to talk to a politician—but I think these are areas of growth for us."

Group, Illinois Department of Public Health, Illinois Department of Children and Family Services, Illinois Department of Alcoholism and Substance Abuse, Illinois Department of Mental Health and Developmental Disabilities, Parents Too Soon.

Reference Committee D

30 (A-86) Adopted
(BOT Report G)—Ad Hoc Committee on the Young Physician
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed the Society to establish an Ad Hoc Committee on the Young Physician to investigate the following: (1) Assess the changing needs of the young physician; (2) Means to increase membership in organized medicine; (3) Mechanisms to encourage active participation in organized medicine; and (4) The difficulties with the transition from resident to regular member.

7 (A-87) Adopted As Amended
ISMS Policy Statement Titled "Immunity"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Adopted the following policy statement:

IMMUNITY
Physicians who serve state or local agencies as volunteers, independent contractors or employees should be provided legal defense, indemnification and appropriate immunity by the governmental agency.

12 (A-87) Adopted
Director of Public Health
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that: (1) The Society support the position that the Director of Illinois Department of Public Health be a physician licensed to practice medicine in all its branches; and (2) That previous House action stating that "Illinois State Medical Society approve the concept of allowing a person other than a physician licensed to practice medicine in all its branches be appointed Director of the Illinois Department of Public Health provided that no qualified physician can be found," be rescinded.

15 (A-87) Adopted
ISMS Policy Titled "Death With Dig-

nity"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the ISMS policy titled "Death With Dignity" be deleted from the policy manual.

16 (A-87) Adopted As Editorially Amended
ISMS Policy Titled "Confidentiality"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Amended the ISMS policy on "Confidentiality" as follows:

CONFIDENTIALITY

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient, and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness.

Section IV of the AMA Principles of Medical Ethics states that: "A physician shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law."

The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of confidentiality of the doctor-patient relationship as it relates to the patient record and will take an active role in uncovering any violation of the doctor-patient relationship by officials and personnel of review organizations and will take whatever steps necessary to eliminate the breach of confidence.



Dr. Alfred J. Kiessel, chairman of the ISMS Board of Trustees, presents his report affirming that all resolutions referred to the Board for action had been implemented. The Board's recommendations on unfinished business were presented by Dr. Kiessel and referred to reference committees for further deliberation during the three-day meeting.

23 (A-87) Adopted
Policy Statement on "Examinations"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the ISMS policy statement titled, "Examinations," be deleted from the policy manual.

25 (A-87) Not Adopted
FMG Representation in the AMA
Introduced by Kishore J. Thampy, M.D., Delegate

Defeated this resolution which asked that the Society direct the delegation to the AMA to support the formation of a representative Section of FMGs in the AMA.

37 (A-87) Adopted As Editorially Amended
Advertising
Introduced by Robert A. Behmer, M.D., Delegate for the Winnebago County Medical Society

Directed that the Society ask the Department of Registration and Education to require all health care licensees to identify in all advertising and promotional materials the specific profession for which they are licensed.



Members of the ISMS Fifty Year Club.

40 (A-87) Not Adopted
Public Perception of Physicians
Introduced by Jaime Cercone, M.D., Delegate for the Fulton County Medical Society

Defeated this resolution which asked that the Society pursue legislation opposing the trend of mistrusting the motives of physicians.



We Don't Have a Health Policy in this Country

Dr. Joan E. Cummings of Glen Ellyn is a former ISMS trustee who has served as chairman of the Society's Policy Committee and Council on Medical Services as well as a member of the AMA delegation. As associate chief of staff for extended care and geriatrics at Edward Hines Jr. VA Hospital, she directs a palliative care unit at the hospital, as well as the hospital based home care program. A board certified internist, Dr. Cummings also has served as president of the Hines-Loyola Branch of the Chicago Medical Society. She is a graduate of the Loyola University Stritch School of Medicine, where she now serves as assistant professor of clinical medicine.

Dr. Cummings says physicians must take the lead in steering public policy.

"Organized medicine provides a forum for open discussion of important issues, but it needs to be willing to get out front and volunteer its expertise to policymakers," Dr. Cummings told *IMJ*.

"We don't have a health policy in this country. We don't have a clear idea of where we're going as a country for health care. We don't know whether 10% of the Gross National Product spent on health care is too much or not enough. I think the country has to address the issue of how much of the GNP is the right amount to provide health care.

"What I see as the most pressing clinical issue is the need to balance technology and its use with patient benefit. The use of expensive technology tends to create a very difficult situation for physicians in terms of capping and cutting of costs.

"So how do you balance use of technology against the physician's role of assessing benefits and providing the care a patient needs? Technological adjuncts are important, but there are problems when the physician is not totally free to make choices about which technology to use. That issue has to be dealt with." ◂

46 (A-87) Adopted As Amended
Modern Communication Technology
Introduced by Eugene B. Loftin, III, M.D., Delegate for the Kane County Medical Society

Directed that the Society continue to determine how and in what areas of membership participation modern communication technology may be further utilized.

49 (A-87) Referred to Board for Study
Anti-Physician Letters
Introduced by Roger N. Klam, M.D., Delegate, Jackson County Medical Society

Referred to the Board of Trustees for study a proposal that the Society ask the United Mine Workers Association Health and Retirement Funds to cease its publishing and mailing of inflammatory, anti-physician letters, so as to eliminate the source of potential hostility and defamation.

Report
Filed for information the following reports:

Illinois State Medical Society Auxiliary, Illinois Society of Medical Assistants, Educational and Scientific Foundation, Hospital Medical Staff Section, Resident Physicians Section, Medical Student Section, Council on Public Relations.

Memorial Resolutions

The House also adopted memorial resolutions in memory of Drs. Charles A. DeKovessey, Martin P. Meisenheimer, Burtis

E. Montgomery, Robert R. Mustell, Richard O. Peach, Jacob E. Reisch, George Shropshear, Peter J. Talso and Jacob Ungar, and expressed its profound loss and condolences to their families.

Elect Officers, Trustees, AMA Delegates

Dr. Allan L. Goslin, Streator, was installed as ISMS President, succeeding *Dr. Jere E. Freidheim*, Chicago.

Election of Officers

At the concluding session of the House, 1987-88 officers were elected unanimously. They are: *Drs. Harry A. Springer*, Evanston, president-elect; *Edward J. Fesco*, LaSalle, first vice-president; *Pedro A. Poma*, Melrose Park, second vice-president; *Harold L. Jensen*, Flossmoor, secretary-treasurer; *Robert M. Reardon*, Bloomington, speaker of the house, and *Joan E. Cummings*, Hines, vice speaker of the house.

Election of Trustees

Elected trustees were: *Drs. David B. Littman*, Highland Park, First District; *Alfred J. Clementi, H. Constance Bonbrest, M. Anita Johnson, Adriano S. Olivar* and *Robert M. Vanecko*, Third District; *George T. Wilkins, Jr.*, Edwardsville, Sixth District; *Phillip D. Boren*, Carmi, Ninth District and *Ronald G. Welch*, Belleville, Tenth District.

Judicial Panel

Dr. Daniel G. Cunningham, Chicago, was elected to serve a five year term on the ISMS Judicial Panel.

Illinois AMA Delegates

The House of Delegates elected AMA delegates and alternates to serve January 1, 1988 through December 31, 1989. Elected delegates were: *Drs. Alfred J. Clementi, Jere E. Freidheim, Allan L. Goslin, Robert C. Hamilton, Harold L. Jensen, Morgan M. Meyer, Harry A. Springer, Arthur R. Traugott* and *Ronald G. Welch.* Elected alternate delegates were *Drs. Randall T. Bellows, Albino T. Bismonte, Ulrich F. Danckers, Earl E. Fredrick, Jr., A. Beaumont Johnson, Silvana Y. Menendez, Robert M. Reardon, Donald K. Rokosch, Joseph H. Skom* and *M. LeRoy Sprang. Dr. Joan E. Cummings* was elected delegate to serve immediately and until December 31, 1988. *Dr. Eugene B. Loftin, III,* was elected alternate delegate to complete unexpired term until December 31, 1988. Elected *Dr. Chester C. Danehower, Jr.*, as alternate delegate to serve immediately and until December 31, 1988. *Scott Bernstein*, medical student, was elected alternate delegate, to complete unexpired term until December 31, 1988.

Rules and Order of Business

Appointed to the 1988 House of Delegates Rules and Order of Business Committee were: *Drs. Orlan W. Pflasterer*, Coulterville, Chairman; *Julius C. Araujo*, Chicago; *Earl E. Fredrick, Jr.*, Chicago; *Joseph B. Perez*, Rockford and *Alan M. Roman*, Flossmoor.

1988 Dues

The secretary-treasurer announced that the per capita dues for 1988 would remain at $273.

Illinois State Medical Society
1987-1988 Board of Trustees

President		Edward J. Fesco, M.D., 206 Marquette St., LaSalle 61301
President-Elect		Harry A. Springer, M.D., 800 Austin St., Suite 610, Evanston 60202
1st Vice-President		Pedro A. Poma, M.D., 675 W. North Ave., Suite 407, Melrose Park 60160
2nd Vice-President		Vacant
Secretary-Treasurer		Harold L. Jensen, M.D., Ingalls Memorial Hospital, Office of Medical Affairs, 1 Ingalls Dr., Harvey 60426
Chairman, Board of Trustees		Alfred J. Kiessel, M.D., 1 Powers Lane Place, Decatur 62522
House of Delegates		
Speaker		Robert M. Reardon, M.D., 1008 N. Main St., Bloomington 61701
Vice-Speaker		Joan E. Cummings, M.D., 11-B, Room 482, Ward 4 West, Bldg. 200, Hines VA Hospital, Hines 60141
Trustees		
1st Dist.	1990	David B. Littman, M.D., 1034 Old Elm Road, Highland Park 60035
2nd Dist.	1989	Ross N. Hutchison, M.D., 126 E. 9th St., P.O. Box 388, Gibson City 60936
3rd Dist.	1989	James H. Andersen, M.D., 141 Breakenridge Farm, Oak Brook 60521
	1990	H. Constance Bonbrest, M.D., 830 S. Ada St., Chicago 60607
	1990	Alfred J. Clementi, M.D., 675 W. Central Rd., Arlington Hgts. 60005
	1989	Audley F. Connor, Jr., M.D., Jackson Park Hospital, 7531 S. Stony Island Ave., Chicago 60649
	1988	Ulrich F. Danckers, M.D., 1040 Monroe Ave., River Forest 60305
	1989	Robert C. Hamilton, M.D., 711 W. North Ave., Chicago 60610
	1990	M. Anita Johnson, M.D., 8620 W. 93rd Place, Hickory Hills 60457
	1988	William J. Marshall, M.D., 2601 Lincoln Hwy., Olympia Fields 60461
	1990	Adriano S. Olivar, M.D., 1423 Chicago Rd., Chicago Heights 60411
	1990	Robert M. Vanecko, M.D., 6200 N. Kilpatrick Ave., Chicago 60646
4th Dist.	1988	Lorris M. Bowers, M.D., 214 NE Glen Oak, Suite 600, Peoria 61603
5th Dist.	1989	Michael C. Snyder, M.D., St. John's Hosp., Dept. of Radiology, 800 E. Carpenter St., Springfield 62702
6th Dist.	1990	George T. Wilkins, Jr., M.D., #1 Glen Ed Prof. Park, Edwardsville 62025
7th Dist.	1988	Alfred J. Kiessel, M.D., 1 Powers Lane Place, Decatur 62522
8th Dist.	1989	Arthur R. Traugott, M.D., 1107 Eliot Dr., Urbana 61801
9th Dist.	1990	Phillip D. Boren, M.D., Doctor's Clinic, South Plum St., Carmi 62821
10th Dist.	1990	Ronald G. Welch, M.D., 333 S. Illinois, Suite B, Belleville 62220
11th Dist.	1989	Raymond A. Dieter, Jr., M.D., 22 W. 240 Stanton Rd., Glen Ellyn 60137
12th Dist.	1989	Raymond E. Hoffmann, M.D., 1030 Highview Ave., Rockford 61107
Trustee-At-Large	1988	Jere E. Freidheim, M.D., Mercy Hospital and Medical Center, Stevenson at King Dr., Chicago 60616
AMA Delegation Chairman *(Ex-Officio)*		Robert C. Hamilton, M.D., 711 W. North Ave., Chicago 60610
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ISMIS Board of Directors *Chairman (Ex-Officio)*		Robert C. Hamilton, M.D., 711 W. North Ave., Chicago 60610

Annual Meeting Highlights

Business matters considered at the 1987 Illinois State Medical Society House of Delegates annual meeting are capsulized in the Summary of Actions. The following material provides brief synopses of selected special presentations.

Physicians attending the 1987 annual meeting enjoyed presentations by key leaders of the Society and state government. Illinois Governor James R. Thompson's comments on legislative and public health matters ranged from proposed tax increases to further malpractice reform. John J. Ring, M.D., vice-chairman of the AMA Board of Trustees and a former member of the ISMS House and Board, talked of professional freedom and the importance of solidarity among physicians. State Representative Alfred G. Ronan (D-Chicago), sponsor of ISMS' 1987 malpractice reform legislation, commended physicians on their level of involvement. Educational presentations by Drs. Freidheim and Goslin, who were then ISMS president and president-elect respectively, outlined legislative strategies for passage of malpractice reforms and a new Medical Practice Act.

Governor Addresses Delegates

ISMS President Jere Freidheim, M.D., introduced the keynote speaker, Illinois Governor James R. Thompson. Dr. Freidheim cited the Governor's support of malpractice reform legislation in 1985 and his establishment of a special Task Force on Medical Discipline.

Governor Thompson vowed continued support for the Society's efforts. "This administration is committed to helping you achieve your legislative goals," he told the House.



Illinois Governor James R. Thompson.

The Governor described his proposed budget for the upcoming year, and sought physician support for proposed tax increases. Governor Thompson outlined five major areas requiring additional funds: education, economic development, welfare reform, transportation, and human services. "I think these are pretty decent priorities," said the Governor, "but they have to be paid for."

Public Affairs Breakfast Features Rep. Alfred G. Ronan

The annual ISMS Public Affairs Breakfast featured State Representative Alfred G. Ronan (D-Chicago). Representative Ronan was primary Democratic sponsor of ISMS' malpractice reform legislation, and had been a key proponent of the Society's 1985 legislative package.

Representative Ronan commended physicians for their efforts through IMPAC and personal lobbying activities supporting the successful malpractice reform legislation in 1985. He emphasized that the medical profession overcame great odds that year, and warned that passage of additional reforms during the 1987 session would be even more difficult.

"The legal community paid attention to what you did two years ago," Rep. Ronan told the audience. He warned that opponents of the medical community's reform measures had organized a much

President's Inaugural Stresses Unity

Allan L. Goslin, M.D., was sworn in as 1987-88 ISMS president on Sunday, April 12. Dr. Goslin's untimely death three weeks later prevented him from fulfilling his term as ISMS president. Under the ISMS Constitution and Bylaws, Edward J. Fesco, M.D., first vice-president, will complete Dr. Goslin's unexpired term.

Excerpts from Dr. Goslin's inaugural address are reprinted below as an example of his vision and the commitment he sought from his colleagues.



A special Chairman's Award is presented to ISMS legal counsel, Saul Morse. Mr. Morse was instrumental in drafting the legislation offered to the General Assembly in 1985, and he played an integral part in defending court challenges to the new law on constitutional grounds.

In his inaugural address, ISMS President Allan L. Goslin, M.D., made a strong plea for physician unity. "As professionals, we must forget about our differences in culture, nationality, race, religion, and think only of the quality of medical care our patients receive. I extend an invitation to you to resist the efforts of those who would divide us along these lines. Medicine must also be unified and strong to keep our house clean . . . . making sure that doctors who shouldn't be practicing are not. We must be sure that our professional medical discipline is as good as it can be. There are a lot of people outside the profession who are trying to make decisions about what makes a clean house of medicine. You and I know the mechanisms are in place and work when used properly. Let's not just talk about weeding out bad doctors; let's make sure we're doing it."

He stressed the importance of enlisting new members, noting, "to be unified as a profession, we must have as many members as possible. Remember, those who aren't members are reaping the benefits from the battles that you and I are fighting. They are getting a free ride. They should be with us."



ISMS President Jere E. Freidheim, M.D. (L) administers oath of office to Allan L. Goslin, M.D.

Dr. Goslin also called on his colleagues to work to improve the public's image of the medical profession. "Be the best person you can be, both at work and at home," he said. "Go out in the community and show your neighbors that you care about what happens in your community. Share your extra knowledge for the good of the community."



Representative Lee Daniels (R-Elmhurst) receives Public Service Award recognizing his community service, work for quality health care and support for malpractice reform.

more concerted effort for the current session.

Nonetheless, Rep. Ronan said he believed that physicians could achieve additional reforms. "But if you're going to be successful," he warned, "you've got to become involved."

Special Awards

Dr. Earl Stockdale, Rock Island, and Representative Lee Daniels (R-



Dr. and Mrs. Jere E. Freidheim



Dr. and Mrs. Lawrence L. Hirsch



Dr. and Mrs. Alfred J. Kiessel



Mr. and Mrs. Alexander R. Lerner



ISMS Auxiliary President Pat Spadoni and Alex Spadoni, M.D.



Dr. and Mrs. Harold L. Jensen

Elmhurst) received special awards at the annual meeting. The Physician Public Service Award recognized Dr. Stockdale's work to encourage immunizations and to organize a physician referral network providing medical care to indigent persons in Rock Island County. Representative Daniels' nonphysician Public Service Award commemorated his work as an advocate of medical malpractice reform. Rep. Daniels' support for quality health care as a board member for two Illinois hospitals and his volunteer work with developmentally disabled children were cited.

A special Chairman's Award was presented to ISMS legal counsel Saul Morse, recognizing "loyal service and sound judgment," as ISMS' legislative counsel as well as a participant in a host of community service activities.

Other awards at the annual meeting included the 1987 Edwin S. Hamilton Interstate Teaching Award, commending Dr. Jack Pickleman of the Loyola University Stritch School of Medicine, and a plaque recognizing years of commitment and leadership presented to Dr Morgan M. Meyer as past chairman and secretary of the ISMS Delegation to the American Medical Association.

President's Address

Dr. Freidheim's president's address followed the awards presentations. He reported that he had been "graciously received and well fed," by the 25 county societies and three CMS branches visited on his president's tour. "I think I logged roughly 4,600 air miles and about 3,400 car miles," he told the House. "You get to see a lot of places on the president's tour. You're in and out awfully quickly but you get to see a lot of places."

Dr. Freidheim recounted pivotal events during his year as president, beginning with the State Supreme Court's ruling on the 1985 malpractice reform legislation. The Court's finding that four of the five tort reform laws which had been challenged were, indeed, constitutional had generated renewed enthusiasm for continued efforts to amend the civil justice system, Dr. Freidheim said. A second area of concentrated effort, he recalled, related to legislative sunset review of the Medical Practice Act.

In addition to these two areas of primary concentration, Dr. Freidheim reported efforts to educate the public through media interviews on such topics as AIDS, physician discipline, mumps and smoking. Editorial meetings with local newspapers also enhanced public education goals, he said, providing dialogue between media representatives and physician leaders.

"I found that although the membership wanted to discuss many different issues, there was always one basic feeling everywhere," he told the House. "We would like to practice our profession. We want to take care of patients without fearing that we might end up in court if our results do not live up to unrealistic expectations. Nor do we want to be

encumbered by undue regulation from those outside of medicine."

Drs. Freidheim and Goslin on Legislation

Upon completion of his president's address, Dr. Freidheim was joined by ISMS President-Elect Allan L. Goslin, M.D., to present a slide show on strategy surrounding ISMS' legislative efforts for passage of malpractice legislation and a new Medical Practice Act. Those efforts, which proved to be quite successful, centered on education.

"Malpractice is *still* the number one problem for the Illinois medical community," said Dr. Freidheim. "ISMS is the best organization to address that problem through state legislative action." He reported results of ISMS-sponsored research on public attitudes concerning the malpractice problem and physician willingness to become involved in the legislative effort. Dr. Freidheim then outlined planned activities for physicians: enlisting public support by educating patients, addressing public groups and the media, and emphasizing strong, aggressive and fair medical discipline.

Dr. Goslin cited a need for physician education with respect to pending revision of the Medical Practice Act. Proposed amendments to the Act were anticipated from other groups—including provisions to expand the scope of licensure for members of other health professions and to require that physicians accept Medicare assignment.

Dr. Goslin provided some general guidelines for legislative action. "Emphasize your concern about the quality of care your patients will receive, not the turf battles among health care team members," he told the House. "Try to take a 'high road' approach, because if you do not, legislators and the public will be quick to assume you are concerned more with your pocketbook than with your patients."

Dr. Goslin emphasized that a successful legislative effort would require that physicians meet with legislators, "go public" about the need for reform, be unified in their approach, and act when called upon by ISMS.

Medical Practice Act Session

Alfred J. Clementi, M.D., the immediate past chairman of the ISMS Board of Trustees and chairman of the Society's Ad Hoc Committee on the Rewrite of the Medical Practice Act, conducted a special informational session.

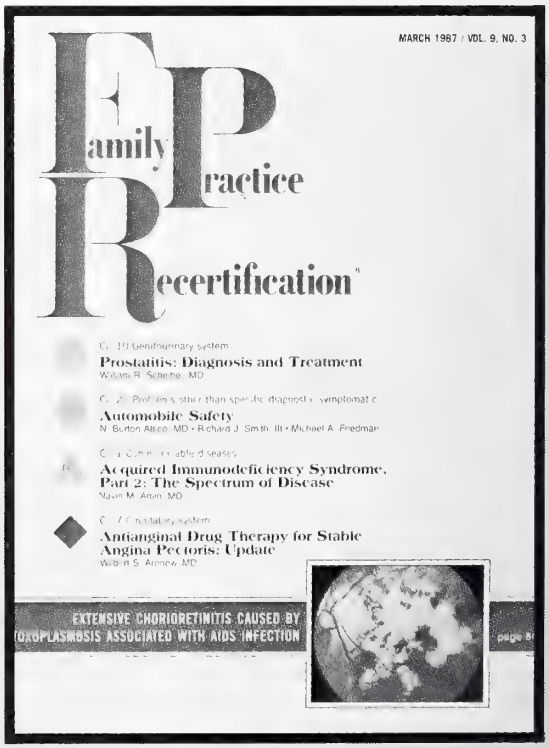
Physicians learned about proposed revisions to the Act supported by ISMS, including revised procedures relating to physician discipline. Dr. Clementi also described attempts by other groups to amend the Medical Practice Act to include mandatory Medicare assignment, mandatory retesting, and automatic license suspension or revocation for a certain number of malpractice suits. ◀

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News from [redacted] **about a new dosage form of cephalexin**

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cephalexin

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Keflet is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

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Indications and Usage: Keflet™ Tablets (cephalexin, Dista) are indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S pneumoniae, Haemophilus influenzae,* staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin-structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis,* and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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The Other Side

BY KENNETH J. HERRMANN,
VICE CHAIRMAN, MSS GOVERNING COUNCIL

With all the gloom and doom we've been reading and hearing about lately it's difficult to see the proverbial silver lining through the daily drudgery of medical school training. With HMOs, anticipated reductions in physician income, estimated physician surplus, the malpractice insurance premium explosion, DRGs, declining physician image, and worsening financial aid opportunities all despoiling the medical profession, it's no wonder many students are apprehensive. I would like to discuss a few of these issues from a slightly different point of view because in order to construct a realistic view of the future, one must see the positive aspects as well as the negative.

It is my opinion that profit seeking HMOs which apply undue economic pressure on physicians who struggle with patient care issues will obtain only a moderate market share of total health care consumption. HMOs target younger, healthier patients who traditionally account for a decreased percentage of health care utilization; therefore, a large percentage of sick patients will be left for non-HMO treatment. Physicians hired by HMOs will have to tolerate pressure from profit-seeking individuals to provide as little as possible as infrequently as possible while still providing a minimal standard of care. These physicians will gain, however, from fixed salaries, employee benefits and more stable and probably shorter work weeks. Some physicians will choose this type of arrangement. Others will not. Other physicians will choose a PPO, group practice, or a combination, based upon the amount of freedom, stability, pressure and monetary reward each individual desires. New forms of practice do not limit physicians' choices, in fact, they add a variety of options to better suit individual preferences.

Another concern is the physician surplus heralded by the infamous GMENAC report. A few points can be raised concerning this study. First, to re-emphasize, although the report suggested a total surplus if all other variables remained the same, regional shortages (opportunities) will still remain. Second, the number of FMGs obtaining residency spots is decreasing. Third, pressure is being applied to medical schools to graduate fewer MDs. Finally, traditional practice and family structure is changing. For instance, traditionally, a one income family structure predominates, in which the physician works long work weeks and the spouse cares for the home (working long hours as well, I might add). Presently, family structure is changing to include more dual income arrangements which may decrease the number of hours worked by the physician spouse, and therefore obscure present GMENAC projections. For example, in a traditional family the physician's hours worked per week may amount to sixty hours; in a dual income family the number may be closer to forty or even less if the physician has child-bearing responsibilities. One must consider number of hours worked in addition to number of physicians available. One must also consider total family income, since although the average physician's hours and income may decrease, family income may remain unchanged or even increase with two members working.

Although there is still a ways to go, medical professional liability tort reform is progressing, and although educational loan interest will no longer be fully deductible, maximum loan interest amounts have increased on major loan programs.

Medicine has much to offer now and will have even more to offer in the future, including a stable income, job security, challenging and interesting work, and most of all, the pleasure that comes with helping patients treat their medical problems. ◀

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Approximately 1,100 injectable drugs contain sulfites as preservatives. These can cause anaphylactic reactions in individuals, particularly asthmatics. Commencing in June, physician package inserts will warn about sulfite content. The Food and Drug Administration has also extended this labeling requirement to non-injectable prescription drugs where sulfites have been directly added as inactive ingredients. (*FDA Drug Bulletin* 17:1,2-3, 1987)

Ten scientists analyzed a series of thermograms of 125 individuals in a double blind case study comparing normal subjects with patients having a history of chronic pain. In normal subjects, daily variations were noted that ranged from 0.5 to 2C. These variations were symmetrical and varied only 1C between right and left. Patients with chronic pain syndromes with a secondary skin surface blood flow alteration showed consistent asymmetric patterns when sensitivity of the thermograph was 0.5C. This was consistent for patients with spinal cord injury. Thermography had mixed usefulness in differentiating pain-free subjects from those reporting knee, leg and back pain. (Sherman, R., *et al.: Arch Phys Med Rehab* 68:5,273-9, 1987)

The incidence of bacterial urinary tract infection was evaluated in 91 residents of a skilled nursing facility. Patients were monitored for up to six years. Forty-one percent were nonbacteriuric, 34% were intermittently bacteriuric, and 25% were continuously bacteriuric. Bacteriuric and nonbacteriuric patients were similar in age, number of diagnoses, medications and mobility. However, bacteriuric patients showed significantly more urinary tract incontinence. After six years no significant difference appeared in the survival rate of the three groups; urinary tract infection contributed to only two deaths. Bacteriuric patients more frequently showed dementia, confusion, and functional disability, but not a higher mortality. (Nicolle, L., *et al.: Ann Int Med* 106:5,682-6, 1987)

The benefits of excessive lowering of diastolic pressures in hypertensive patients was questioned in a retrospective study of 902 patients who had received a beta blocker for hypertension control. Patients, followed for 10 years, were treated with antihypertensives for blood pressure (BP) of 160/95 in patients less than age 40, 160/100 in those 41-55, and 170/105 in those aged 56 and older. The study concluded that lowering the diastolic BP below 85mmHg increased the incidence of death from myocardial infarction. (Cruickshank, J., *et al.: The Lancet* 8533:1,581-4, 1987)

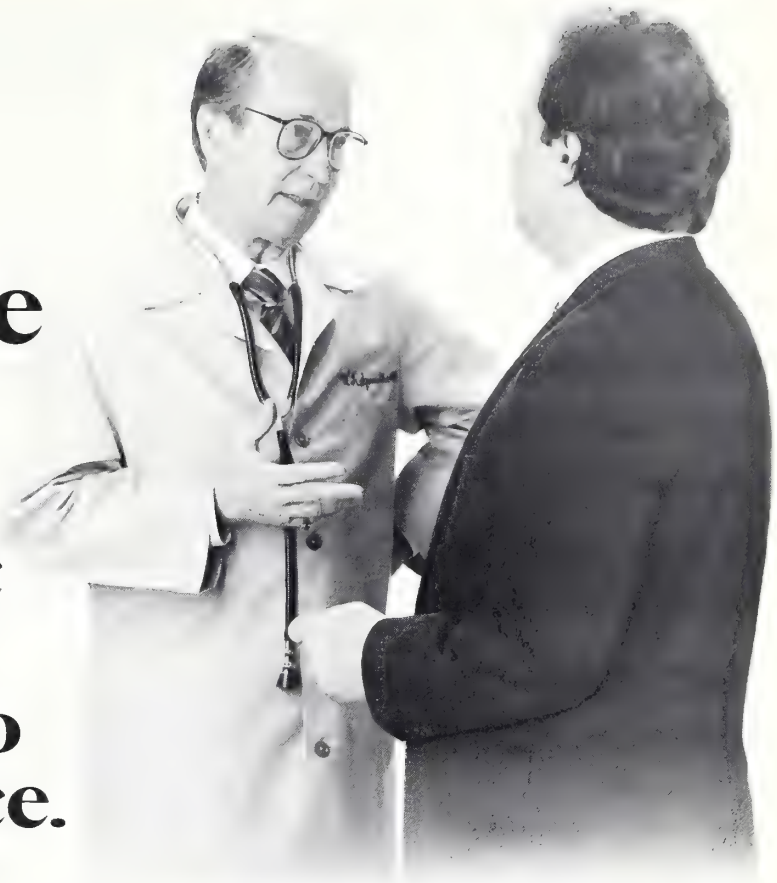
Curtailing alcohol intake in hypertensive patients may lead to improved blood pressure control. Forty-four males on antihypertensive medication were evaluated biochemically for alcohol intake and their blood pressures were measured. When low alcohol beer was consumed blood pressure dropped approximately 5mmHg systolic, 3mmHg diastolic. (Puddey, I., *et al.: The Lancet* 8534:1,647-51, 1987)

Rheumatologists report that fibromyalgia is one of the most common diagnoses in ambulatory practice—3-6 million patients appear to have this syndrome. A total of 118 of 250 patients evaluated with fibromyalgia fulfilled the diagnostic criteria. Criteria consisted of: generalized aches, pain or stiffness absent other systemic conditions to account for these symptoms; and multiple tender points at characteristic locations. Other minor symptoms included disturbed sleep, tiredness, subjective swelling, headaches, or irritable bowel syndrome. Treatment for these patients is nonspecific, but reassurance, counseling, judicious medications and physical therapy may be beneficial. (Goldenberg, D.: *JAMA* 257:20,2782-7, 1987)

A retrospective study on tubal infertility and the type of contraception used was evaluated between 1981-1983. The contraceptives used by 283 nulliparous infertile women and 3833 women admitted for childbirth were compared. Past use of oral contraceptives did not affect a woman's risk of tubal infertility. Rather, risk varied according to the content of estrogen and type of progestogen in the contraceptive. Double barrier methods using both chemical and mechanical barriers (diaphragm, cervical cap, or condom plus spermicide) offered the best protection against tubal damage, compared to single barriers. (Cramer, D., *et al.: JAMA* 257:18,2446-50, 1987)

A multicenter, randomized, prospective study compared patients assigned for bypass surgery to those treated medically. Operative mortality was 4.1%, and 74.8% of grafts studied arteriographically were patent one year later. The crossover rate from medical management to surgery was 34% within a two-year period. The mortality rate for those who required bypass surgery after medical management was 10.3%. The incidence of nonfatal myocardial infarction was 11.7% in the surgically-treated group and 12.2% in the medically-treated group. Patients with unstable angina had a similar outcome for a two-year period whether treated surgically or medically. When the left ventricular ejection rate is reduced, surgical intervention is suggested. (Luchi, R., *et al.: N Engl J Med* 316:16,977-984, 1987)

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Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

August

Medicine

Specialty Review in Internal Medicine
For: Internists and medical subspecialists, Lecture, August 2-8, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $765. **Reg. Limit:** None. **Credit:** Category 1: 62 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Obstetrics and Gynecology

Gynecologic Surgical Techniques
For: Obstetricians and gynecologists. Lecture/Workshops, August 20-22, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $515. **Reg. Limit:** 90. **Credit:** Category 1: 21 hours; Other: 19 Cognates Formal Learning (ACOG). **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Orthopedic Surgery

Practical Management of Orthopedic Infections
For: Physicians. Seminar, August 7, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $100. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours. **Contact:** Loretta Giacoletto. **Photo:** (800) 325-9862.

Pediatrics

Specialty Review in Neonatology/Perinatology
For: Pediatricians and obstetricians. Lecture, August 24-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $640. **Reg. Limit:** None. **Credit:** Category 1: 57 hours; Other: 57 PREP hours (AAP). **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Psychogerontology

Third Congress of the International Psychogeriatric Association
For: Interested physicians. Symposium and workshops, August 28-31, Palmer House, Chicago. **Sponsor:** International Psychogeriatric Association, 259 E. Erie, Rm. 448, Chicago IL 60611. **Fee:** $320. **Reg. Limit:** None. **Credit:** Category 1: 1 hour of credit for every hour attended. **Contact:** Jill Cohen. **Phone:** (312) 908-1248.

Surgery

Specialty Review in General Surgery, Part I
For: General and specializing surgeons. August 17-28, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $880 **Reg. Limit:** None. **Credit:** Category 1: 96 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

September

Anesthesiology

The Use and Interpretation of Monitoring New Technologies
For: Anesthesiologists. Symposium, September 11-13, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 15.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Cardiology

Contrast Echocardiography Symposium: New Techniques in Profusion Imaging, Contrast Echo and Esophageal Imaging **For:** Cardiologists. Symposium, September 17-18, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $100. **Reg. Limit:** 125. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

General Practice

40th Annual Clinical Refresher
For: Interested physicians. Lectures and workshops, September 16-19, Chicago. **Sponsor:** Chicago College of Osteopathic Medicine, 5206 S. University Avenue, Chicago, IL 60615. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 18-24 hours. **Contact:** Marie Kowalsky. **Phone:** (312) 947-4606.

Psychiatry/Family Practice/Internal Medicine

Eating Disorders
For: Physicians and allied health professionals. Conference, September 22-23, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, and University of Wisconsin Hospital, Eating Disorder Program. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 20 hours; AAFP Prescribed and American Dietetic Association: credit pending; and University of Wisconsin CEUs: 10 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

October

Critical Care Medicine

Sixth Annual Chicago Critical Care Symposium
For: Physicians, physicians-in-training, and nurses. Lectures and panel discussions, October 15, Chicago Downtown Marriott Hotel. **Sponsor:** University of Health Sciences/The Chicago Medical School, Department of CME, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** To be determined. **Reg. Limit:** None. **Reg. Deadline:** October 15. **Credit:** Category 1: 24.5 hours; and AAFP Prescribed: to be determined. **Contact:** Ben Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Psychiatry

The Psychiatric Interview
For: Psychiatrists, Course, October 23-25, Holiday Inn Mart Plaza, Chicago. **Sponsor:** University of Chicago Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** 175. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

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If so, contact the PHYSICIAN HELP LINE, 312/580-2499, a confidential, advocacy service offered by the ISMS Impaired Physician Program and the Physician Support Group to link troubled physicians and their families with resources to help them.

The Physician Help Line is open 24 hours, 7 days a week. Calls will be answered as soon as possible, and information is shared only with the physicians helping the person who calls.

Medical Society and Auxiliary

Synergy in Action

By Lynn Kassel, President, ISMSA

A decade ago, under the tutelage of AMAA's current president, Betty Szewczyk, ISMSA strategically planned ways to increase membership during the organization's second 50 years. The presence of the medical society was expanded in the community through health projects initiated by county auxiliaries. As directed by the ISMS 27 years before, auxiliary continued to work as the arm of medicine.

As ISMSA approaches 60 years as an organization, the planning committee looks to the future, seeking what it can offer organized medicine. Today's society demands teamwork on the part of the medical society and auxiliary. Services and benefits from the national and state segments of our federation need to expand to assist members in the county. Our plans include:

- ☐ computerized membership information and billing;
- ☐ ready-made health programs;
- ☐ marketing techniques for physician offices;
- ☐ estate and trust programs;
- ☐ political information and direction; and
- ☐ friendship and support.

The cost of offering these benefits is relatively small—$15 to AMAA and $15 to ISMSA. The county level adds additional dues based on organizational needs. Much recent legislative success has been directly attributable to auxiliary, and many inquiries about joining are due to the spouse's desire to be active in the political arena.

If your medical society does not have an active auxiliary, why not seek a representative? Membership in auxiliary provides access to information affecting the future of the physician's family. The personal and financial costs are mimimal. ◂

Viewbox

(Continued from page 6)

Diagnosis: Wandering spleen

At laparotomy, the spleen was enlarged and was located in the left lower quadrant. It was on a long pedicle that lacked any ligamentous attachments. No gross evidence of splenic infarction was observed, and a splenectomy was performed.

The mass is identified on computed tomography (CT) as a wandering spleen by its characteristic cross-sectional shape and homogeneous density, discernable hilar vessels, and absence of the spleen in the left upper quadrant. The diagnosis of a twisted ovarian cyst is unlikely because the patient is postmenopausal. The clinical presentation is atypical for an abscess. Wandering spleen is the only choice associated with medial displacement of the splenic flexure.

Discussion

When the ligaments that maintain the spleen in the left upper quadrant are deficient or absent, the spleen is able to migrate from its usual position in the abdominal cavity. This condition is most commonly called a wandering spleen, but is also known as ectopic, ptotic, floating, displaced, or aberrant spleen.[1] It must be differentiated from such unrelated conditions as accessory spleens, splenosis (autologous extrasplenic implants), and a rare positional anomaly of little clinical significance known as an "upside-down" spleen.[2]

Wandering spleen is rare. In a large number of splenectomies done for all reasons, it occurred in zero to 0.3% of cases.[1] Only about 400 cases have been described.

Etiology

Congenital and acquired factors both contribute to a wandering spleen. Congenital maldevelopment of the spleen in the dorsal mesogastrium may lead to laxity or absence of the supporting splenic ligaments.[1] Since the colon also develops in the dorsal mesogastrium, the occasional association of a wandering spleen with a hypermobile colon can be explained by a common embryologic malformation.[3,4] The rare occurrence of an intraperitoneal (rather than retroperitoneal) distal pancreas with a wandering spleen can also be similarly explained.[3,5]

Acquired factors include laxity of the abdominal wall and the hormonal effects of pregnancy, which promote stretching of the splenic ligaments. Females with wandering spleen outnumber males by 20:1; most patients are multiparous females aged 20 to 40 years, although males and children are also affected.[1] Intrinsic enlargement of the spleen may also contribute. Enlargement has been due to infection, neoplastic and traumatic conditions.[1] Finally, gastric dilatation may accentuate splenic displacement.[1]

Clinical Presentation

Wandering spleen may present in one of three ways:[1]

1. *The patient is asymptomatic.*
   The ectopic spleen is discovered incidentally as a mass on physical examination or on an imaging study.
2. *The patient has recurrent symptoms.*
   This is the most common presentation of wandering spleen. There is a chronic course with episodes of mild- to-severe abdominal discomfort, usually with a palpable, often tender, abdominal mass. Spontaneous torsion and de-torsion of the splenic pedicle produce temporary splenic congestion which accounts for the intermittent vague abdominal pains and evanescent masses that are associated with this clinical presentation.[1] Digestive disturbances (nausea, vomiting, change in bowel habits) may accompany the onset of symptoms,[6-8] and menstrual irregularities have been reported.[6,7]
3. *The patient has an acute abdomen.*
   Acute volvulus of the splenic pedicle occludes the vessels leading to infarction. The patient presents with an acute abdomen, and a painful abdominal mass is present in over 90% of cases.[6] A history of recurrent abdominal pain is often given.

Complications

A wandering spleen, because of its more exposed anatomic position, is more susceptible to traumatic injury.[9] Pelvic spleens have ruptured during pregnancy.[10]

Chronic splenic torsion occasionally leads to splenic vein thrombosis, and the resultant left-sided portal hypertension may produce gastric varices (which resolve after splenectomy).[11,12] Gastric torsion may occur because the spleen is not present in the left upper quadrant to prevent organoaxial rotation of the stomach.[12] Torsion of the splenic pedicle may involve the distal pancreas, causing pancreatitis,[5] or may involve a loop of bowel, giving rise to a bowel obstruction.[8] Rarely, the long splenic pedicle may compress and obstruct the colon.[3] Chronic torsion may produce perisplenic adhesions.[13]

Important complications of acute splenic torsion include hemorrhagic infarction of part or all of the spleen, splenic gangrene, abscess, and degenerative cyst formation.[13] The mortality rate with acute torsion is about 50%.[1]

Diagnosis

The preoperative diagnosis of symptomatic wandering spleen is made infrequently, presumably because of the rarity of this condition, the nonspecific clinical findings and the evanescent signs and symptoms of chronic splenic torsion.

Correction

Correctly supplied materials were reversed in printing of the Viewbox column for our May issue. The figures are shown as they should have appeared; an explanation is detailed below at right.



Figure 1—May issue
Small bowel examination shows displacement of intestine in the right lower quadrant. (arrowheads) Image provided by Joseph Porada, M.D., St. James Hospital, Chicago Heights.

These figures appeared on page 275 of the May *IMJ*. Figure 2, correctly provided by Joseph Porada, M.D., of St. James Hospital, was intended to illustrate a large collection of fat visible by computed tomography. This, in conjunction with Figure 1, supported the diagnosis of Crohn's disease with fibrofatty proliferation of mesenteric fat. Unfortunately, Figure 2 was flopped, or reversed in printing. We regret this error and any attendant inconvenience it may have caused.

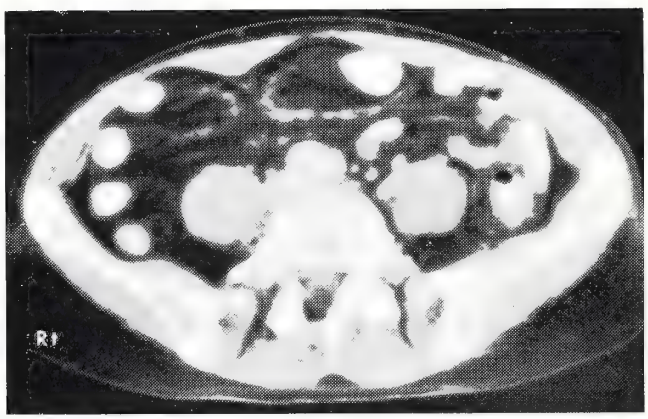


Figure 2—May issue
Corrected reproduction of CT image at the same level as the displaced bowel. Image provided by Joseph Porada, M.D., St. James Hospital, Chicago Heights.

A clinical triad has been proposed to identify cases of wandering spleen:[4] (1) a palpable, hard, ovoid abdominal mass with a notched edge; (2) painless manipulation of the mass toward the left upper quadrant, but painful movement in any other direction; and (3) a resonant left upper quadrant. However, case reports rarely document any finding but the first. Moreover, the splenic notch may not always be palpable—it may be obscured by splenic congestion[14]—or the spleen may be rotated, making the notch inaccessible.

The preoperative diagnosis of wandering spleen relies principally on imaging studies. Plain films of the abdomen, excretory urography, barium gastrointestinal studies, sonography and computed tomography can demonstrate findings that are suggestive of the diagnosis. (Table 1) Although sonography or CT may supply adequate information to establish the diagnosis, radionuclide scanning and angiography are considered to be confirmatory studies.[1]

Sonography is efficient, noninvasive, cost-effective and does not involve ionizing radiation. CT is useful especially when sonography gas artifacts make it impossible to define the pancreas or the position of the spleen.[5] Unlike radionuclide scanning, both ultrasound and CT are able to image the spleen when there is complete obstruction of vessels following volvulus of the splenic pedicle.

Scintigraphy with Tc-99m sulfur colloid is organ-specific for the liver and spleen, so it may identify the spleen regardless of its location. It is also a relatively

Table 1
Radiographic Diagnosis of Wandering Spleen[1]

Plain films	Mobile soft tissue mass in abdomen or pelvis. Spleen absent from normal position.
Excretory Urography	Elevation of left kidney with absent splenic hump. Ureteral compression above pelvic brim without lateral displacement.
Barium GI Studies	Mass effect. Stomach positioned high in left upper quadrant (with or without inversion). Anteromedial displacement and excessive mobility of true splenic flexure. Bandlike impression (from splenic pedicle) in area of splenic flexure.
US/CT[15]	Cross-sectional shape and homogeneous appearance characteristic of spleen. Spleen absent in left upper quadrant. Recognition of hilar vasculature (may be able to trace their origins proximally).
Scintigraphy	Splenic activity in abnormal location with no uptake in left upper quadrant. Decreased or absent uptake of colloid in torsion.
Angiography	Spleen and splenic vessels in abnormal location. Pedicle vessels may appear twisted. Compromised splenic blood flow with torsion.

cost-effective study. Torsion of the splenic pedicle may be indicated by decreased or absent uptake of colloid by the spleen,[5,16] as splenic activity is dependent on splenic perfusion. A lack of uptake in torsion may be difficult to differentiate from "functional asplenia," which has many causes.[1]

Angiography is the most definitive method to diagnose wandering spleen.[1] The location of the spleen and its vascular anatomy (including varices) may be visualized along with the site of torsion. Splenic vein occlusion may also be detected.[5] Angiography is invasive, so it should probably be reserved for confusing cases in which the diagnosis remains in doubt, or when the vascular anatomy must be defined prior to surgery.[5]

Treatment

Until recently, splenectomy was considered to be the treatment of choice for all cases of symptomatic wandering spleen. The loss of the spleen was regarded as relatively innocuous, and splenopexy was believed to be ineffectual because of technical failures. Interest in saving splenic tissue has been renewed because of the increased susceptibility of splenectomized patients to develop overwhelming sepsis—a vulnerability that is not limited by the age of the patient or the length of time after surgery.[17]

Splenopexy is advised if the spleen appears viable at laparotomy, and a number of techniques to repair a wandering spleen have been described.[4,14,18] Given the dire consequences of post-splenectomy sepsis (an overall case fatality rate of 50%),[17] some would revise a failed splenopexy rather than resort to splenectomy.[14] The patient should undergo physical examinations and sonography at regular intervals to monitor for recurrence of a wandering spleen.

If the spleen is nonviable, with massive infarction and thrombosis of the splenic vessels, then splenectomy is necessary.

Unfortunately, no one therapeutic measure has been found to protect completely against post-splenectomy sepsis.[16] A polyvalent pneumococcal vaccine should be given before or directly after splenectomy, although the efficacy of the vaccine is not absolute.[17] Furthermore, pneumococcus causes only half the cases of sepsis in this population. Other important pathogens include *Neisseria meningitidis, Escherichia coli,* and *Hemophilus influenzae.*[17] Immunoprophylaxis against meningococcus[14] and *Hemophilus*[17] has been advocated.

Prophylactic use of penicillin (or trimethoprim-sulfamethoazole in the case of penicillin allergy)[17] has been recommended for at least two years, in addition to immunization,[10] but there are notable problems with compliance in prophylactic drug regimens.[17] Medical identification should be worn,[14] and the patient advised of the immediate seriousness of any type of febrile illness or infection.

There are conflicting data concerning the protective value of autologous transplantation of splenic tissue (splenosis) during splenectomy. Neither this technique, nor the presence of accessory spleens at surgery, should be relied on for protection against post-splenectomy sepsis.[17]

The likelihood of torsion in an asymptomatic patient with a wandering spleen is unknown. Some advocate a conservative, non-surgical approach,[1,6] but they consider splenectomy as the only other treatment alternative. The potential for torsion in these cases has led to the recommendation of surgery,[7,10,20] especially in children, who supposedly have a higher incidence of torsion.[20] Splenopexy would also reduce the susceptibility of wandering spleens to traumatic injury. ◀

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AIR FORCE

EKG

(Continued from page 8)

Answers: 1. C, D 2. C, D

The twelve lead ECG shows sinus rhythm with 2:1 AV block best seen in leads V_1 and V_2. Abnormal symmetrically inverted T waves are seen, as well as a long Q-T interval of 0.52 seconds. The ventricular rate is 44 beats per minute. There is a sharp spike following every QRS by 840mSec. This is a pacemaker spike which fails to capture the ventricles. The pacemaker is sensing the preceding QRS at a consistent cycle length of 72 beats per minute but cannot capture the ventricles. The patient's heart rate drops back to her intrinsic sinus rhythm with 2:1 AV block and a ventricular rate of 44 beats per minute.

There is no evidence for an inferior myocardial infarction, and no premature ventricular beats are present. The bradycardia allowed congestive heart failure to develop. Increased furosemide dosage helped relieve some of her dyspnea. However, pacemaker replacement was needed.

Pacemaker failure can develop at the pacer electrode-myocardial interface, in the pacer electrode itself, or in the pulse generator and battery unit. Myocardial metabolic or fibrotic charges could cause elevations in the pacing threshold. Pacer lead fractures can also result in pacer failure. Finally, pulse generator and battery failures can result in pacemaker failures.

In our patient, the pacemaker unit, as well as the pacer electrode, were replaced. This new pacemaker with increased furosemide eliminated the symptoms of congestive heart failure. Later, the dose of furosemide was reduced to her previous dose. ◂

Illinois License Renewal Information

July 31, 1987, is the deadline for Illinois physicians to renew their licenses. The renewal period is three years at $100 per year, or $300. Physicians should pay the full amount, even if they are contemplating closing their practice or leaving Illinois before July 31, 1990.

Physicians should also pay the $15-per-office-location controlled substance licensure fee if they want to continue to prescribe. The $15 fee also covers the three year period.

Physicians should *not* check the "inactive" category unless they have decided not to practice medicine or prescribe medications in Illinois for the next three years. A $100 penalty will be imposed on physicians who allow their licenses to lapse after July 31, 1987. Physicians who have not received a renewal notice should call the Illinois Department of Registration and Education at (217) 782-0458.

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Exchange Insights

July 1987

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

Informed Consent

A physician may be accused of negligence or battery (the intentional touching of another's person without authorization) if he fails to obtain a proper informed consent from his patients prior to rendering medical treatment. The objective of the consent process is to provide patients with the opportunity to make an informed decision about whether to undergo a prescribed course of medical treatment. To fulfill this objective, the patient must be provided the appropriate information to make an educated and objective evaluation of the risks and benefits associated with the suggested treatment. As a result of the consent process, informed patients, who are fully aware of the potential risks of a treatment beforehand, are less likely to bring legal action even if the results are not what they desired.

The Informed Consent Discussion:

The informed consent discussion gives the physician a unique opportunity to build rapport and establish trust with his patients. More importantly however, it is through the consent discussion that the physician educates the patient so that he can arrive at an informed, intelligent decision about his medical care. But what *kind* of information and what *amount* must the doctor dispense to enable a patient to make this decision?

Depending on the circumstances, a proper informed consent discussion will often include:

- ☐ a summary of the diagnosis in lay language;
- ☐ the rationale for, and description of, the recommended treatment;
- ☐ a disclosure of the possible risks and probable consequences that may occur, including severity and frequency;
- ☐ an explanation of the anticipated benefits;
- ☐ a description of the prognosis, realistic treatment goals, and probability of success;
- ☐ a discussion of any reasonably available alternative treatments;
- ☐ information about potential outcomes if the suggested treatment is refused,
- ☐ a request for the patient to repeat back what the physician has informed him, encouraging the patient to ask questions; and
- ☐ ample time for the patient to reflect on what the physician has told him.

In discussing the above information, many physicians are concerned about the *amount* of information to disclose. They fear that either patients will refuse a treatment when they are exposed to the potential risks of that treatment, or attorneys will claim that the physician did not provide sufficient information to allow a patient to make an informed decision.

Generally, a physician is required to disclose that amount of information that is given by other physicians in the community in the same or similar circumstances. This amount is established by an expert witness.

Physicians are also required to provide the patient sufficient information to enable any reasonable person in a similar situation to make a decision. The definition of "reasonable," however, varies from patient to patient. The amount of information disclosed is generally based on the patient's informational needs. Therefore, practitioners need to be aware of the level of disclosure necessary for and desired by their patients. This level is based on the patient's capacity and willingness to understand the consequences of a procedure. The standard does require, however, that a physician discuss any risks that may

be material or significant in influencing the patient's decision. It is therefore suggested that physicians disclose both the severity of the risks and their likelihood of occurring.

Patient Education Materials:

To supplement the information presented to the patient through the consent discussion, many physicians provide a pamphlet, a video/audiotape, or any other educational tool. This gives patients the opportunity to digest the often complicated and stress-producing information in the privacy of their home and to discuss it with their family. In this way, if and when the patient decides to undergo the proposed treatment, the decision will be a much more deliberated, intentional one. The more considered the decision, the more valid the consent.

Only the physician should participate in the consent discussion and obtain the actual consent. However, it is acceptable for a staff member to present patients with printed supplemental information or to help execute the consent form. If the patient indicates to a staff member that he is willing to sign the form and go ahead with the treatment, but that he is not sure he understands all the ramifications, the physician should be informed in order to respond to the patient's questions.

Documentation Of The Informed Consent:

A signed consent form by the patient does not necessarily prove that the consent obtained was an *informed* one. Therefore, it is important that the physician document in the patient's chart that a consent discussion took place and the patient agreed to proceed with the suggested treatment. To accomplish this, the doctor may simply note that he and the patient discussed the patient's medical condition, the nature of the suggested treatment, the associated risks and benefits and alternatives, and that the patient said he understood, agreed to proceed, and signed the consent form. It is also recommended that the physician note in the record who else was present during the discussion, such as a family member, and what, if any, educational materials were given to the patient.

Informed Refusal Of Treatment:

If, after the consent discussion, the patient is unwilling to undergo the recommended treatment, procedure or test, the record should indicate that the patient was warned about the potential risks and consequences involved in refusing treatment. The physician may even wish to have the patient sign a refusal form indicating that the possible consequences were explained, and that the patient still refused the test or procedure.

When An Informed Consent Is Not Required:

There are a few defenses to a suit based on a lack of informed consent. However, it is imperative that the physician document in writing the facts leading to his decision not to obtain the patient's informed consent based on any of the following instances.

Patient Waives Disclosure: A patient, who wants to proceed with the recommended treatment, does have the right to request that he not be told about the treatment's potential risks and consequences. However, it is strongly recommended that the doctor have the patient sign a form indicating that he does not wish to be informed. This form should be placed in the patient's file.

Common Risks: When a risk of a procedure is too minor and is commonly known, then it is not necessary that the risk be discussed with the patient. However, it is always safer for the physician to assume that risks are not known to patients, and should therefore be disclosed.

Emergency Situation: If the patient is unable to consent, *i.e.*, is unconscious, or if taking the time to obtain the patient's consent could put the patient's life in danger, then the physician may treat the patient without the threat of liability based on the physician's failure to obtain informed consent.

Therapeutic Privilege: If the physician judges that disclosure of the potential risks and consequences of a proposed treatment would upset the patient so much that the patient would be unable to make a rational, informed decision, then the patient's consent may be waived. However, the fact that informing a patient of potential risks might produce anxiety is not reason enough to withhold information from the patient. In fact, it is recommended that a family member be informed of the potential risks that are being withheld from the patient—not to obtain the consent of the family member, but for informational purposes. In addition, it is important to document in the patient's record what information is being kept from the patient, and the reasons why.

In summary, the process of obtaining the patient's informed consent consists essentially of a discussion between the doctor and the patient. It is the physician's duty to assure that the patient has understood the information he has presented so that the patient can make an educated decision. It is the patient's duty to evaluate the information his physician has presented, and to weigh the advantages and disadvantages of undergoing the proposed treatment in order to arrive at an informed decision.

Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

BOT Abstracts

(continued from page 12)

ucts be recommended for inclusion in the IDPA Drug Manual: Vaseretic (enalapril, hydrochlorothiazide); and Atrovent (ipratropium bromide).

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Carrington Dermal Wound Gel (allantoin); Senokot (senna concentrate); Aclovate (alclometasone dipropionate); Fibercon (calcium polycarbophil); Diasorb (attapulgite); and Persantine (dipyridomole).

OTHER ACTIONS

In addressing various other issues, the Board:

- Filed the Financial Statements for the period ended January 31, 1987; March 30, 1987 IMPAC Collection Data; March 27, 1987 Dues Payment Report; and approved Requests for Changes in Membership Status.
- Rescheduled its June meeting to be held Thursday, June 25, 1987, at 2:00 p.m.
- Agreed that a "rolling rally;" whereby physicians and other interested parties be encouraged to come to Springfield, be held once a week for four weeks as part of PLI II.
- Approved the retention of various policy statements, in keeping with activities to review all existing policy over five years old.
- Agreed to: (1) endorse the editorial content of a Medicare Part B Brochure; and (2) publish the brochure as recommended by the Third Party Payment Processes Committee.
- Agreed to invite *Illinois Medical Journal* Editorial Board Chairman J. William Roddick, Jr., M.D., to a future ISMS Board of Trustees meeting to receive an award and official greetings from the ISMS Board.
- Agreed that draft discipline language regarding inspection of physicians' offices be amended to provide that the Medical Disciplinary Board may issue an order authorizing ". . . an appropriately qualified investigator employed by the Department to enter upon the business premises of the subject with due consideration for patient care . . ."
- Agreed to support a licensure requirement of a three year residency. Subsequent to the Ad Hoc Committee on the Re-Write of the Medical Practice Act meeting, ISMS leadership met with representatives of the Resident and Student Sections to discuss this position.
- Agreed with the proposal to rename the Medical Practice Examining Committee in the Medical Practice Act as the Medical Licensing Board, to be appointed by the Governor.
- Approved Draft 10 of the proposed Medical Practice Act.
- Authorized the Executive Committee to decide on a Broker of Record for the consolidation of members' insurance programs.
- Approved publication (in whole or in part) in the *Illinois Medical Journal* of the AMA Council on Ethical and Judicial Affairs Report A (I-86) on Conflict of Interest, as an educational tool for the membership.
- Approved a modified position on Allied Health Personnel, subject to appropriate review by legal counsel.
- Agreed that ISMS not sponsor its own English language program for physicians, but instead, through the Illinois Board of Higher Education, compile a listing of English language adult education courses available from high schools, community colleges and universities, and make these programs known to physicians through county medical societies, the *Illinois Medical Journal* and letters to Illinois residency directors.
- Referred back to the Council on Education and Manpower for further study the definition of physician extenders.
- Adopted positions recommended by the Governmental Affairs Council on a list of primary bills pending in the 85th General Assembly.
- Agreed to write the Illinois High School Association and urge that organization to form a medical advisory committee to provide medical input into the rules and programs affecting high school athletes. In addition, ISMS would offer to nominate physicians to serve on that body for the IHSA.
- Referred back to the Council on Medical Services a recommendation that the Board inform the IDPH Clinical Laboratory and Blood Banking Board that: (1) ISMS support the concept of allowing licensed clinical laboratories to provide tests which may be available over-the-counter, at the request of an individual; and (2) a lab performing such OTC tests should designate a physician to counsel a patient whose results are in the "panic level."
- Agreed to send a letter to the Illinois Alcoholism and Drug Dependence Association endorsing their effort to obtain grant funds to educate IV drug users about AIDS prevention.
- Discussed the current draft of the rules to designate Trauma Centers in Illinois and agreed to support the concept that "the designation of specialty care centers should be based on the quality of medical care provided and the ability of a hospital to fulfill its purpose. Patient outcome should be one of the major criteria to determine continuing designation of Trauma Centers."
- Agreed to delete positions titled "Family-Centered OB Care" and "Lay Persons in Delivery Suites" from Official ISMS Actions.
- Approved nine recommendations made by the Council on Public Relations and Membership Services as a result of a study called for by Resolution 30 (A-86). This resolution directed ISMS to study the problems of young physicians (defined by the AMA as a physician in the first five years of practice, or a physician, not a resident, who is under 40 years of age.)

- Approved proposed revisions to the ISMS Goals and Objectives.
- Approved that one issue of the *Illinois Medical Journal,* on a yearly basis, be used as a report to the membership on the Society's annual activities.
- Elected Dr. Alfred J. Kiessel, Decatur, as Chairman.
- Nominated Drs. Phillip D. Boren, Alfred J. Clementi, Ulrich F. Danckers, Robert C. Hamilton, Jerry M. Ingalls and Alfred J. Kiessel, for the ISMIS Board of Directors.
- Appointed Alexander R. Lerner as proxy for the shareholder, Illinois State Medical Society, at the annual meeting of ISMIS, May 6, 1987, to cast the proxy vote for Directors of ISMIS.

NOMINATIONS AND APPOINTMENTS

The Board made the following awards, nominations and appointments:

- Named Jack Pickleman, M.D., Loyola University Stritch School of Medicine, as the 1987 recipient of the Hamilton Teaching Award presented on behalf of the Interstate Postgraduate Medical Association of North America.
- Nominated Drs. Violet Eggert, Maureen Bohnsak, William Weigel, Helen Morrison and Tim Miller, to serve on a conference committee to develop a program on perinatal substance abuse in conjunction with DCFS/DASA.
- Approved that Drs. Alan Roman, Flossmoor, and Michael Davidson, Oak Park, be continued as the delegate and alternate to the AMA Young Physicians Section Assembly at the 1987 AMA Annual Meeting.
- Nominated Dr. Peter Friedell, Chicago, for reappointment to the Illinois Cancer Council's Board of Trustees.
- Nominated Dr. Samuel Gaines, Springfield, to serve on the Illinois Advisory Council on Alcoholism and Substance Abuse.

SEMINARS AND PROGRAMS

The Board:

- Endorsed the application of IDPH to receive cancer control funds from the federal government as an extension of previous efforts which have been supported by ISMS in the past.
- Ratified co-sponsorship of the Eighth Annual AMA Conference on the Impaired Physician.
- Ratified co-sponsorship of the IDPH survey of obstetrical and family physicians regarding obstetrical care in Illinois.

OTHER MATTERS

The Board:

- Received a report on current litigation challenging a portion of the 1987 Medical Malpractice Reform Act, and other litigation dealing with hospital medical staff issues.
- Noted current activity regarding opposition to DRG application for hospital-based physicians.
- Heard a report from Market Opinion Research on the results of the research for PLI II.
- Officers and trustees completing terms of office were presented plaques in appreciation of their service.
- Certificates of appreciation were presented to ISMS staff members, Richard Ott for 20 years of service, Anne Drucker and Rose Anne Christiansen 15 years, and Jackie Burkhart, Cheryl Koos and Tom Sullivan 10 years.

INFORMATIONAL ITEMS

The Board:

- Heard a report that HCFA funding for PRO will be cut by 20%.
- Noted that Ms. Edie Zusman, AMA Alternate Delegate, has resigned and accepted a residency in California.
- Heard and discussed current PRO activities, Cost Containment Council and DRGs, and review of the Office of Contractual Services.
- Heard informational reports from the Committee on CME Accreditation, Committee for the Impaired Physician, Illinois State Medical Insurance Services, Hospital Medical Staff Section, Resident Physicians Section, Medical Student Section, AMA Delegation Chairman and AMA Trustee Dr. John J. Ring.

NEXT MEETING

The next Board of Trustees meeting was set for 2:00 p.m., June 25, 1987, at ISMS Headquarters.

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—to join an established four member group of general internists in Bloomington-Normal, Illinois. Complete office facilities. Midwestern University community with strong economic base. Contact: Judy Buchanan, Administrative Director, The Health Center, 702 North East Street, Bloomington 61701, (309) 827-5051. (6)

CLIFTON:
Board Certified OB/GYN. 70 miles south of Chicago. Rural community hospital. Service area population 10,000. Excellent financial benefits, including guaranteed income, modern office space adjacent to hospital, staffing and moving expenses. Contact: Dianne Soucie, Administrator, Central Hospital, P.O. Box 68, Clifton 60927; (815) 694-2392. (10)

FLORA:
Population of county 15,000 +. Opportunity for General Surgeon supported by three FP, OB/GYN, Internist, and Hand Surgeon. Progressive family-oriented community, excellent school system. Close to St. Louis, Springfield, & Evansville. Contact John Monnaham, Administrator, Clay County Hospital, 700 North Mill, Flora, IL 62839. (10)

GIBSON CITY:
Opportunities for Family Practice and Internal Medicine either in partnership with a family practitioner or in solo practice. Fully equipped office facility and income support arrangements available. Stable farm community serving 20,000 population within a 20-mile radius. 30 miles north of Champaign-Urbana. Three hour drive south of Chicago. Contact: Terry Thompson, Administrator, Gibson Community Hospital, 1120 North Melvin Street, Gibson City 60936, (217) 784-4251. (4)

GRAYVILLE:
On Interstate 64, population 3,000. 64,000 medical market area. New completely furnished medical clinic facility. Financial package, twenty minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: Rebecca S. Alcorn, 320 S. Second Street, Grayville 62844, or call (618) 375-2171 weekdays and (618) 375-3431 evenings and weekends. (6)

LA HARPE:
Rural western Illinois community of 1500 (service area of 5,000) is seeking a Family Physician. Good schools, close to Mississippi River, within 25 miles of university. Small community hospital affiliated with regional medical center. Guarantee plus moving expenses. Contact: Byron Mueller, M.D., 112 Main St., La Harpe 61450, (217) 659-7613; or Richard Miller, Administrator, La Harpe Hospital, B St. & Archer Ave., La Harpe 61450, (217) 659-3011. (6)

OQUAWKA:
General Practitioners/Family Practitioners. Ideal facilities in a rural community in beautiful western Illinois. Excellent income potential and fringe benefits; no capital investment; CME available; hospital affiliation; shared call with second physician; all administrative duties handled by efficient, dedicated staff. Contact: Bayard S. Galbraith, Adm.; The Health Center; P.O. Box 118, Oquawka 61469; (309) 867-2202. EOE (9)

PITTSFIELD:
Illini Community Hospital. Practice opportunities for FP, OB/GYN, Internist and Pediatrician; solo or partnership. Office space and financial assistance available. Service area 25,000. Excellent outdoor recreation. Close to St. Louis and Springfield. Good school systems, including colleges and universities. Contact: Kathleen Wegener, 640 W. Washington, Pittsfield 62363, (217) 285-2113. (2)

Job Hunting Part Two

By Robin Bluestein, CMA-C

Part one of this article, published in the May IMJ, *addressed experience and preparation/planning for the potential medical assistant position. This article will focus on job interviewing and making the most of your job after being hired. (Editor's Note: This series of articles was originally printed in the May and July 1986 issues of* IMJ. *It is being reprinted to satisfy the large number of requests received for this information.)*

You have sent a resume and/or answered a position advertisement. It's wise to follow up with another letter or telephone call. This will express your continued interest in the position and enhance their interest in you.

When an interview has been scheduled, preparation is very important. Consider your responses to probable questions the interviewer might ask. Why are you applying for this position? What do you feel you can contribute to this position? What are your interests? How do you feel you work with other people?

Next, compile a number of questions that you might have for the interviewer. What will your responsibilities be? What are some of the job benefits? Is there room for advancement? Many more questions can be created and you should determine how you would answer them. Answering these questions will help prepare you for the interview.

Salary will be a major concern. What kind of salary can you expect? What salary do you feel you deserve with your experience and abilities? Determine the salary you would like to make and be willing to negotiate to some extent. Unfortunately, it was my experience that offices were offering much less than I was willing to make. I found that employee turnover was very high in these offices. This told me that "they were getting what they paid for." It was my belief that if offices and physicians were willing to pay more for quality employees, job satisfaction would be high and physicians would benefit from their medical assistants' proficiency and contentment.

If possible, apply for several positions. Shop around for a position that fits your needs. Do not panic and think that this is the only position you will be offered (this happens occasionally with first-time job hunters). You may be surprised by the different positions you will be offered. Take your time to find the right spot.

The final concern is making the most of your job after being hired. Undoubtedly, you will be proficient in many office responsibilities, but some tasks must be learned. Offer to take a class to learn audiometry, show interest in a course on computerizing your office, or suggest that the entire office staff become certified in cardiopulmonary resuscitation (CPR). Your enthusiasm and interest will benefit your office and be an added plus for you (in your office and in general).

Some jobs are permanent. Some are just stepping stones to bigger and better things. Do not stay in a job where you do not grow or a job that you do not enjoy. If it is a comfortable position, but you are not growing, consider another option.

You can always go back to square one: check the Sunday advertisements, see what is available and take if from there. Good luck in your job search!

Information regarding the Illinois Society and/or medical assisting can be obtained from Cheryl Hutchison, CMA, president, Illinois Society, 53 Lockhaven, Granite City 62040. ◀

CLASSIFIED ADVERTISING

Classified Advertising Rates

	25 words or less	26 to 50 words	51 to 75 words	76 to 100 words
1 insertion	$ 7.00	$17.00	$25.00	$ 42.00
3 insertions	13.00	32.00	46.00	78.00
6 insertions	18.00	44.00	64.00	108.00
12 insertions	22.00	53.00	79.00	132.00

All proposed advertisements should be received by the first of the month preceding publication. A surcharge of $5 will be assessed when a box number is requested and an additional 18 words should be added in calculating the advertising rate.

POSITIONS AND PRACTICE

PEDIATRICIAN TO JOIN well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, IL 60178.

INTERNIST WITH SUB-SPECIALTY in rheumatology to join well-established primary care group. We are a midwestern community, 60 miles west of Chicago, near a major university. Compensation and fringe benefits are negotiable. Reply to Dr. Irving Frank, 954 W. State Street, Sycamore, IL 60178.

ORTHOPAEDIC SURGEON— Join large Illinois manufacturing company as a full-time employee orthopaedic consultant. Some office orthopaedics, benefits consultation, cost containment, workers compensation evaluations, etc. Candidate must be board certified, licensed in Illinois, have recent private practice experience, very good written and oral communication skills, and a self starter. Salary is competitive plus liberal company fringe benefits including malpractice and relocation expenses. Send full curriculum vitae to Box #2041 c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WOMEN'S ORIENTED MEDICAL Clinic looking for family practitioner or internist—room to grow. 45 miles west of Chicago. Reply to Women's Health Center, 1240 North Highland Avenue, Suite 17, Aurora, IL 60506.

PRIVATE PRACTICE OPPORTUNITIES: Family practice, internal medicine, no cash outlay, attractive salary, excellent incentive compensation, liberal benefits including malpractice. Prospective: OB/GYN, pediatrics, psychiatry. Send C.V. to Don Hoit, Farris & Associates, Inc. 16216 Baxter Road, Suite 200, Chesterfield, MO 63017; (314) 532-4880.

LOCUM TENENS, OPHTHALMOLOGY: Illinois licensure and insurance required. Reply to Box #2050, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Deborah Bergun, Staffing Specialist. National Emergency Services, Inc. 255 Executive Drive, Suite 104, Plainview, NY 11803; or call (800) 645-4848, or (516) 349-0100.

WELL ESTABLISHED PRACTICE general surgery and general practice looking for associate who will buy within six months to one year or right now. 40 miles from Chicago. Twenty years established practice, excellent income. Substantial income from hospital on trauma call. Reply to Box 2061, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CARDIOLOGY: 56-MD multispecialty group seeking second cardiologist to associate in an excellent growing consultative practice, combining both invasive and non-invasive opportunities. Well equipped offices in a modern, accredited facility. Drawing area nearly 400,000 with two well-staffed, modern hospitals. Stimulating Midwest "Big-10" university community of 100,000 with superb cultural advantages. Ideal for family. Medical school teaching affiliation if desired. Excellent initial guarantee and fringes with early associateship and subsequent income based exclusively on productivity. Send C.V. to Box #2056, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ARIZONA-BASED Physician Recruiting firm has urgent requirements coast-to-coast for BC/BE psychiatrists. Excellent hospital-sponsored solo and group practice opportunities. "Quality Physicians for Quality Clients since 1972." All inquiries confidential. Call (602) 990-8080; or send C.V. to: Mitchell & Associates, Inc, P.O. Box 1804, Scottsdale, AZ 85252.

PEDIATRICIAN TO JOIN well established 15 physician multi-specialty group. Excellent fringe benefits with early partnership opportunity for board certified or board eligible physician. Call or write Richard N. Motley, clinic manager, The Hannibal Clinic, 711 Grand, Hannibal, MO 63401; (314) 221-5250.

FAMILY PRACTITIONERS: The Monroe Clinic, located 40 miles south of Madison, has openings in New Glarus and Brodhead, Wisconsin, satellites and new clinic in northern Illinois. Excellent benefits. Partnership available. Resources of 55-physician multispecialty group. Contact Robert H. Rieder, Administrator, The Monroe Clinic, 1515 Tenth Street, Monroe, WI 53566; (608) 328-7381.

MEDICAL DIRECTOR for not-for-profit, urban community health center. Require strong community/public health commitment, BC in primary care area, experience in administration and clinical care. Desirable:

Spanish knowledge. Salary commensurate with experience/skills. C.V. to: Executive Director, Erie Family Health Center, Inc., 1656 W. Chicago Ave., Chicago, IL 60622.

FAMILY PRACTITIONER: Eight doctor multi-specialty group, thirty miles southwest of Chicago seeks a young board eligible family practitioner (OB work available) to join growing practice. Incentive plan, profit sharing, relatively new clinic building with multiple ancillary services. Excellent practice opportunity in community with quality grade and high schools. Guaranteed salary with many fringe benefits for two years, then full partnership. Contact: Frank Schibli, Administrator, Hedges Clinic SC, 222 Colorado Avenue, Frankfort IL 60423; (815) 469-2123.

FAMILY PHYSICIAN: Walnut Illinois. Located in north central Illinois, 2 hours east of Chicago, one hour west of the Quad Cities. Town of 2,000; 6,000 within 10 mile radius. Solo or group (4 other F.P.s in nearby towns). Clinic and other incentives available. Close to 97-bed hospital with good specialty mix. Send C.V. to Bill Spitler, Perry Memorial Hospital, 530 Park Avenue East, Princeton, IL 61356. Phone (815) 875-2811.

FAMILY PRACTICE physician for lovely downstate Illinois community (city population 6,000; county 18,000). Growing, progressive hospital with a tradition of excellence. Region offers both urban and rural amenities—group or solo practice options available. Call or write Dr. Wendell C. Trent, Lawrence County Memorial Hospital, 2200 West State Street, Lawrenceville, IL 62439; (618) 943-1000.

FP(BC/E): Not-for-profit, urban community health center addressing needs of medically underserved, culturally diverse population offers unique practice opportunity. Strong commitment to excellent, accessible, multidisciplinary care and health promotion. Spanish knowledge desirable. C.V. to: Executive Director, Erie Family Health Center, Inc., 1656 W. Chicago Ave., Chicago, IL 60622.

OB/GYN: PHYSICIAN NEEDED For family planning clinic and pregnancy terminations in Chicagoland area. Send resume to All Management Consultants, P.O. Box 2237, Des Plaines, IL 60017.

ARIZONA-BASED Physician recruitment firm has quality opportunities coast to coast. Available positions in most primary care and surgical specialties to include OB/GYN, orthopedics, ER, and ENT. "Quality Physicians for Quality Clients since 1972." Call (602) 990-8080; or send CV to: Mitchell & Associates, Inc., PO Box 1804, Scottsdale, AZ 85252.

OB/GYN, ORTHOPEDIC SURGEON, Family practice, general internist, ENT and pediatrician—needed for two-hospital, historic river town of 20,000. Drawing area of approximately 60,000 with new 19,000 acre recreational lake. Unlimited potential. Contact Carol Neil, Physician Recruitment, 623 Broadway, Hannibal, MO 63401 or call (314) 221-3107.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has full-time private practice opportunities for the following specialties: board eligible or board certified internal medicine, and board certified family practice and pediatrics. Positions include income guarantee and no capital investment. For more information, contact Barry R. Trautman, 3663 Lindell, St. Louis, MO 63108; (800) 443-3901.

ORTHOPEDIC SURGEON. An excellent opportunity for an orthopedic surgeon to join a single specialty four-man group that is expanding. Prefer hand or spine fellowship training but will consider general orthopedist. Clinic located within new 300 bed hospital complex. Community offers educational and recreational opportunities. Guaranteed salary and excellent fringe benefits. Send curriculum vitae and letter of inquiry to: Clinic Coordinator, Bone & Joint Clinic, S.C., 425 Pine Ridge Blvd., Suite 300, Wausau, WI 54401. Phone: (715) 842-3202.

GENERAL SURGEON for lovely downstate Illinois community (city 6,000; county 18,000). Growing, progressive hospital with a tradition of excellence. Region offers urban and rural amenities. Guaranteed income practice options available. Contact: Dr. Wendell C. Trent, Memorial Hospital, West State Street, Lawrenceville, IL 62439; or (618) 943-1000 (collect).

PHYSICIANS NEEDED: Part-time/full-time for family practice, OB/GYN and pediatrics in Chicagoland area. Send resume to All Management Consultants, P.O. Box 2237, Des Plaines, IL 60017.

HEALTHLINE PHYSICIAN SERVICES, an affiliate of St. Louis University Medical Center, has part-time and full-time opportunities available for physicians in emergency department, clinic and locum tenens work. Excellent compensation, flexible schedules, administrative opportunities and benefits, no "on-call" responsibilities and a challenging medical environment. If you are just starting out, looking for a career change, or want to supplement your income from another source, please contact Barry Trautman, Healthline Physician Services, 3663 Lindell, St., Louis, MO 63108; (800) 443-3901. We are presently recruiting for emergency departments in St. Louis city and metropolitan area.

ILLINOIS ACADEMY of Family Physicians has available an opportunity service for its members to use. IAFP has detailed information concerning over 150 opportunities of different types throughout the state. To receive complete information, mail your C.V. to IAFP—1200 Harger Road, Suite 722, Oak Brook, IL 60521.

FAMILY PRACTITIONER. Board certified or eligible to join 11 physician, expanding multispecialty practice in northern Wisconsin. Clinic adjoins JCAH hospital. Rural location with abundant outdoor recreational opportunities, small four year college. Excellent salary and benefits. Call collect (715) 532-6651 or send curriculum vitae with names of references to: John Smylie, Administrator, Marshfield Clinic—Ladysmith Center, 906 College Avenue W., Ladysmith, WI 54848.

EVANSVILLE, INDIANA. Immediate position available for board certified family practitioner in busy, growing network of ambulatory care centers. Excellent income. Flexible scheduling. Contact MEC Medical Centers, 3844 First Avenue, Evansville, IN 47710, Attn: Rebecca Parker.

INTERNIST, BC/BE, Needed to join four physician practice. $9,000 per month salary, possible bonus, plus full benefits. Full partnership available. Located one hour from Memphis, Tennessee, on I-55. Send C.V. to: Merrill J. Osborne, M.D., Tenth and Highland Streets, Blytheville, AR 72315; or call (501) 762-5360.

PACIFIC NORTHWEST. Wenatchee Valley Clinic, an 105-physician, multi-specialty group practice with seven satellite locations is seeking the following physicians to join the main facility in Wenatchee: pediatrician, allergist, nephrologist, general internist, and psychiatrist. Excellent compensation and benefit packages available. Wenatchee, population 45,000, is located on the Columbia River in the foothills of the Cascade Mountains, providing excellent recreational opportunities in a family-oriented rural setting. If interested, send C.V. to Dr. Gerald Gibbons, Medical Director, Wenatchee Valley Clinic, 820 N. Chelan Avenue, Wenatchee, WA 98801; or call (509) 663-8711, ext. 205.

ARIZONA-BASED PHYSICIAN Recruiting firm has opportunities coast-to-coast. "Quality Physicians for Quality Clients since 1972." Call (602) 990-8080; or send C.V. to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252.

FAMILY PRACTITIONER. Marshfield Clinic—Durand Center is seeking a board certified/board eligible family practitioner to join another family practitioner in an established office based practice in western Wisconsin. Rural location with abundant outdoor recreational opportunities. The Durand Center offers the autonomy of a private, primary care practice plus the financial and professional resources of Marshfield Clinic, a 250-physician multi-specialty group. Full hospital privileges at the local hospital in Durand. Excellent salary and fringe benefits. Please send curriculum vitae to: Robert Peterson, Director, Regional Centers, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449. Or you may call collect (715) 387-5498.

ORTHOPEDIC SURGERY—opportunities throughout the Midwest and Colorado. These positions offer both general orthopedic practices, along with subspecialized training. Partnership and group settings. Contact: Jean Malkasian, 250 Regency Ct., Waukesha, WI 53186; (414) 785-6500 (collect).

PRIMARY CARE PHYSICIANS—Arizona based physician recruitment firm has various opportunities for BC/BE internists, FP's, and pediatricians coast-to-coast. For further information, contact Mitch Young at (602) 990-8080; or send C.V. to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252.

GALESVILLE, WISCONSIN—Family practice. Immediate family practice opportunity available in rural community—population 1,300 with service area of about 8,000. Newly remodeled, fully equipped branch office is part of 51-physician multispecialty group with 16 family physicians. Diverse subspecialty backup and on-call coverage provided. 23 miles from 350-bed, full-service hospital in LaCrosse. Clinic offers competitive compensation package, including first year guarantee and excellent benefits. Galesville is nestled amidst the picturesque bluffs of southwestern Wisconsin. Year-round recreational resources nearby. Contact P.S. Shultz, M.D., Medical Director, Skemp-Grandview-LaCrosse Clinic, 815 S. 10th St., LaCrosse, WI 54601. Phone (608) 782-9760.

FP/GP NEEDED for 20,000 population town drawing 100,000. Immediate opening as medical-director. Established center. Call after 5:00 p.m. (217) 342-9693.

UROLOGIST—VA Medical Center, Lincoln, Nebraska. Seeking board certified or board eligible urologist for progressive, affiliated 180-bed medical center. Center is affiliated with University of Nebraska for urology residency progam. Salary and bonus pay commensurate with training and experience. Licensure any state. Must meet English proficiency requirement. Allowable moving expenses payable. Write or call: (402) 489-3801, ext. 229. Chief, Surgical Service, VA Medical Center, 600 S. 70th St., Lincoln, NE 68510. Equal Opportunity Employer.

WANTED: ILLINOIS Licensed physicians to perform life insurance histories and physicals. Also ECG. (312) 763-8744.

FAMILY PRACTICE/Internal medicine—full time position in group practice requiring light trauma/industrial experience. Practice is located within the near north side of Chicago and is affiliated with a large teaching medical center. Send C.V., references, and salary requirements to: Jean Fagan, Diversified Health Services, The 3 C's Medical Center, 750 W. Montrose, Chicago, IL 60613.

PSYCHIATRIST for busy hospital/office private practice. Immediate opening with opportunity for partnership. Northwest Chicago suburbs. Forward C.V. to Box #2072, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS (Chicago,. West & Central Areas): Seeking emergency medicine physicians for full time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

DERMATOLOGY—opportunities throughout the Midwest and Pennsylvania. These positions offer both general practice along with subspecialized training. Excellent guarantees. Partnership, group, and solo positions available. Contact: Jean Malkasian, 250 Regency Court, Waukesha, WI 53186, (414) 785-6500 (collect).

SITUATIONS WANTED

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box #2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DIAGNOSTIC RADIOLOGIST: Board certified, interventional and imaging fellowships, experienced in all modalities, seeks locums short term. Available most weekends, some weeks including weekdays. Reply to Box #2051, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WANTED PRIVATE GENERAL or internal medicine practice. Chicago or suburbs. Reply to Box #2065, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy at (312) 337-4221.

FOR SALE, LEASE OR RENT

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)662-1664 or (312) 244-3357.

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GENERAL INTERNIST. Invest in yourself! One suite remaining in new medical building with numerous specialties now represented. Located in university town in Dunes country of southern Lake Michigan, fifty miles from Chicago. Superior schools, many recreational opportunities, small town atmosphere. Join other physicians now in independent private practice. Achieve your optimum potential by beginning your own practice in this beautiful new building. Complete lab and x-ray. May invest in building or rental available with large subsidies for beginners. Three minutes from 400-bed hospital with all medical facilities. Contact: Thomas J. Covey, M.D.; (219) 462-4167.

FOR SALE: ADR 4000 SL Ultrasound machine; price negotiable, Oak Park. (312) 383-9729.

FOR SALE—Family practice by board certified M.D. established 40 years; grossing $200,000 plus. Currently without O.B. with minor surgery. Limitless opportunity for young energetic physician. Town 50,000—15 miles east of St. Louis. Two hospitals supplying coverage in all specialties. Reply to Box #2057, c/o Illinois Medical Journal, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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PENTHOUSE—See it to believe it. Grecian columns, Roman mirrored ceilings, walls of mirrors. On the beach and park. Lake Shore Drive view—fairyland day or night. Southeast view—sun and 60-70 feet of windows. View the lake from any room. Two bedrooms, 2 baths. 1700 square feet. 7 cedar walk-in closets. $175,000 or ? Call (312) 878-1818.

SUBLET DOCTOR'S OFFICE, North shore suburbs, modern building near hospital, complete facilities, available September 1987, terms negotiable. Phone: (312) 432-8432.

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MISCELLANEOUS

MEDICAL PRACTICE SALES and appraisals. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004; (215) 667-8630.

DISCOUNT HOLTER SCANNING Services starting at $35.00. Spacelabs holter recorder (cassette) available from $1275.00. Cardionostic holter recorder (cassette) available from $995.00. Smallest and lightest holters update. Fast service (24-48 hrs turn over). Hookup kits starting at $4.95. Special introductory offer of three free tests with any purchase or lease of the recorder. Cardiologist overread available for $15.00. If interested call (301) 870-3626.

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"De Gustibus Non Est Disputandum"



Latin, the language of the civilized world for centuries, is now said to be "dead." But, phrases such as the above live on: "Tastes are not to be disputed."

Who can tell you, an informed adult, what you should admire, enjoy or consume? We like to think that we make up our own minds about lifestyle, notwithstanding the efforts of the vast advertising industry to affect (and perhaps alter) our choices. Look at the vast array of catalogues, appeals, flyers and mailings we receive daily seeking to persuade us to part with some of our income, to espouse some cause or to purchase some object. We are fertile prospects for all of the above and end up on all the high-income mailing lists.

It is difficult for me to write on "tastes," but bear with me. I recently came across a photo in a newspaper that then got on the wire for national distribution. It showed six "doctors" standing by their various luxury and foreign automobiles outside of a prestigious country club, each with his own golf bag and dressed in designer clothes. There was a one-line ascerbic sniping headline comment under the picture, and the effect was devastating. No text was necessary. The picture, as they say, told the story.

The public awareness of "doctors" has changed in recent years. We are no longer held in the highest regard when compared to other categories of profession or employment. Part of this decline is due to the public perception of the way "doctors" live.

This erosion of the public respect and esteem for our profession is what concerns me. We are trying to change the minds of the public and their elected representatives. We want them to hear our pleas and concerns about the malpractice crisis, AIDS legislation, Medicare and Medicaid fees and third party payor pressures. We should not give the enemies of organized medicine grist for the mill to grind us down.

Conspicuous consumption and luxury purchases which draw attention to the cost of things can tend to draw attention and alter public perception. They tend to give the impression that doctors are rich, and tend to flaunt it with a "let them eat cake" attitude. Of course, almost all the physicians we know are hard working, abstemious and concerned about their patients and the community they live in. Physicians, as a group, are not given to "high life and misdemeanors," and think long and hard about what kind of new car to buy, for instance. (In the 1950s, some of us may remember, a doctor in a rural community had to drive a Buick because that was expected of him—but only when he had been in practice for a while. For a new, young physician, a Chevy or Ford was in order.)

Truthfully, each of us has probably indulged in some conspicuous purchases for a spouse, child or ourselves, but I would like to tickle that slight amount of guilt we felt when we did so. We know we are watched and gossipped about and we should try to recall the origins of that "guilty feeling." We are a service profession and when we left medical school and the hospitals we trained in, we started with an ideal to serve our patients and to help heal them with our recently gained knowledge and skills. The money we were to make was definitely not our major concern. True, we had debts to pay and we had to pay our expenses but we knew we could get by. Some of us have changed all or part of our priorities since then. Let's hope we always watch the way we are going.

So, with the above written and having to confess my own lapses of disputed tastes I would enjoin you to remember your ideals and how great they made you feel when you first started in your professional practice. In the doctors' lounges and over the coffee tables, let's talk about our image and burnish it a bit, so that we reflect the true image of our profession. We can work to correct some of the perceptions the public has of the way we live and our priorities. Thank you. ◀

Edward J. Fesco, M.D.

Edward J. Fesco, M.D.
President



Here Today. Here Tomorrow.

Today, most commercial professional liability insurers have abandoned the Illinois market. But there's still one company writing malpractice coverage up to $2 million per incident with a $4 million aggregate—the Illinois State Medical Inter-Insurance Exchange.

The Exchange is the only malpractice insurer in Illinois that is owned and operated by physicians. As such, we are totally committed to meeting the insurance needs of our policyholders. And we intend to be there as long as they need us.

Despite the recent explosion in medical malpractice litigation, the Exchange remains in good shape financially. Much of our success can be attributed to the willingness of the company's physician directors to make tough decisions—decisions like the switch to a "claims-made" policy form...the setting of adequate premium levels...and the strengthening of standards for renewing coverage and accepting new policyholders.

In the continually changing liability climate, the Exchange's directors will continue to make the sound business decisions necessary to ensure the company's long-term financial stability. But as physicians themselves, they also will be making those decisions from a policyholder's perspective. And that will translate into the best possible insurance coverage available, including...

...aggressive defense of frivolous claims;

...policyholder participation in any decision to settle a claim or suit;

...peer review of an adverse underwriting or claim decision;

...help for policyholders in avoiding the situations that can lead to suits; and

...premium rates that fairly reflect the risks inherent to the physician's own practice.

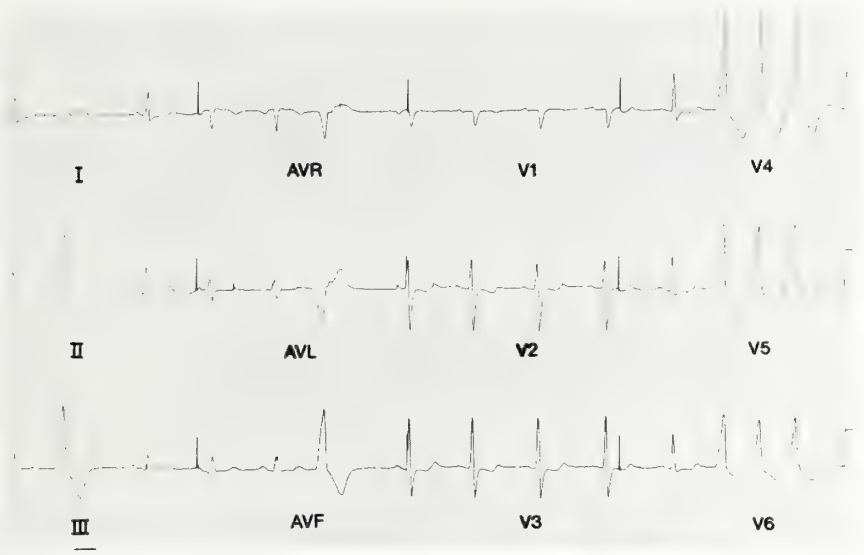
As a company owned and operated by physicians, the Exchange exists solely for the benefit of its policyholders. Some 9,000 physicians in Illinois are depending upon us. And we don't intend to let them down.

ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE

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(Toll-Free)

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was a sixty-six year-old woman who had a dilated cardiomyopathy for one year. One month prior to this hospital admission, she was found to have oat cell carcinoma of the lung and was started on chemotherapy. At this admission she was experiencing episodes of weakness several times a day. Spells were sudden in onset and abrupt in relief. They were unpredictable but totally incapacitating, forcing the patient to lie down until they passed. The spells occurred several times a day, but were never associated with syncope, chest pains, dyspnea, or a sense of palpitations.

The patient's past history was important only for a fifteen pound weight loss over the past three months. Physical examination showed a blood pressure of 130/76mmHg, a pulse of 70 beats per minute with normal pulmonary findings and an atrial gallop (S_4) on the cardiac exam. A complete blood count showed a hemoglobin of 8.9gm%, a hematocrit of 27%, and a white blood cell count of 3800. Chest x-ray showed cardiomegaly unchanged from earlier films and a left lower lobe infiltrate that was smaller than previously shown. This twelve lead ECG was obtained.

Questions:

1. **The twelve lead ECG shows:**
   - A. An acute anteroseptal myocardial infarction.
   - B. Cycle dependent complete left bundle branch block.
   - C. Non-specific ST-T wave changes.
   - D. Right ventricular hypertrophy.
   - E. Premature ventricular beats with a run of ventricular tachycardia (a triplet of ventricular beats).

2. **Which of the following would be most helpful in this patient's management?**
   - A. Serial twelve lead ECGs.
   - B. Stress exercise ECG test.
   - C. Continuous electrocardiographic monitoring.
   - D. Twenty-four hour ambulatory ECG monitoring (Holter).
   - E. All of the above.

(continued on page 133)

THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Do You Know Them As Well As They Know You?

"What's sauce for the goose is sauce for the gander"

Is your professional life an open book? Who is aware of your ownership interest in a hospital, clinic, lab, nursing home, pharmacy, x-ray facility, emergency room or other medical organization? Who knows the specialists you refer to, or the lab and radiology providers you use? Who knows the number of patients you see a day and their age range? Or the average number of patients you admit to a hospital a month? Who knows the amount and carrier of your malpractice coverage? Who knows if you have ever had a malpractice settlement or decision against you, or if your license has been suspended or revoked? Who knows your educational background?

If you have completed an application for participation in an alternative delivery system, the HMO, PPO or IPA may know the answers to all these questions. Information which you may consider confidential may now be part of the open files of any business entity. By signing the application you may have given the HMO or PPO permission to consult with anyone having information related to your application. You may have granted permission for the examination of any documents, reports or recommendations they may have regarding you. In addition, you probably also have given permission to anyone possessing such information to freely give it to the HMO or PPO, and have released the HMO or PPO from liability related to its "good faith" use of such information received from other parties.

Once you embark on this new relationship, your professional reputation and financial well-being may become tied to your new contractor. Part of the normal risks of participating in contracts for the delivery of medical services is that you may be joined in lawsuits with your new association.

They know you, *but how much do you know about them?*

Are they credit worthy? Who serves on the board of directors? Do they operate within Illinois under other names? Will they provide you with audited financial statements for the past three years, or at least for as long as the business has been operating? Will they provide you with a list of participating physicians you can use for reference purposes? Are you aware that some contracts specifically provide that you will *not* receive a list of other participating providers until *after* you sign the contract? Will the organization share with you a list of the employer groups currently receiving health benefits because of a contractual relationship with the business? Are you aware that some contracts specifically provide that you will *not* find out who the contracting employer groups are until *after* you sign your participating contract? What is the plan's marketing strategy and is it being marketed to employees who are already your patients? Does it indicate that your participation will preserve or increase your patient base?

In malpractice litigation involving alternative delivery systems it should be expected that in many cases both the physician (and/or IPA) and the HMO or PPO will be sued, and that the plaintiff will try to prove that both parties were responsible for the injury. If, for example, the judge or jury decides that the physician and HMO are jointly liable for the injury, but only the physician has the financial ability to pay the judgment because the HMO is either uninsured or insolvent, then the physician most likely will be responsible for the entire judgment.

Is your new associate required to carry professional liability insurance? Does the professional liability insurance coverage include coverage for physician's participation on utilization and quality control com-

mittees established by the organization? Does the business subcontract for utilization review activities? If so, is the subcontractor required to carry professional liability insurance or does the business' policy extend coverage to the subcontractor? Is the business currently being sued in a professional liability lawsuit? Is the business currently under investigation by any federal or state agencies? Can the business assign the contract to another business? Has any physician ever received a dollar back from the risk-sharing pool? Is the target utilization rate for specialty and hospital care realistic? How does actual utilization compare with the target?

They know you but how well do you know them? Because you're an informed physician who recognizes the complex issues involved in contracts for the delivery of medical care, your first step is to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you objective comments on any HMO, PPO or IPA contract. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

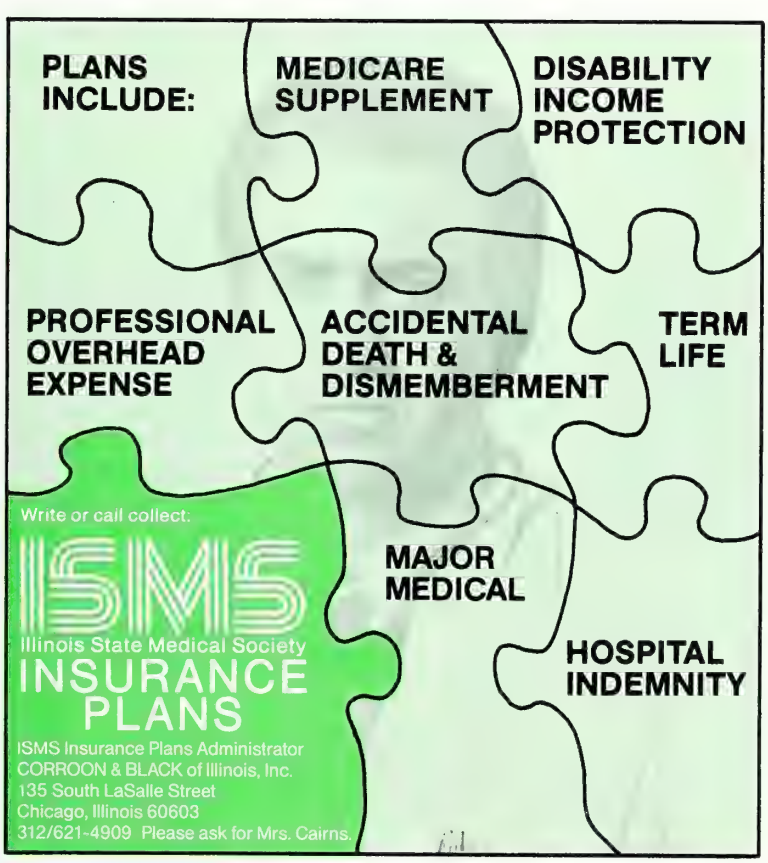
Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

SOLVE YOUR PROTECTION PUZZLE

The insurance puzzle... are there pieces missing from your picture?

As a member of ISMS, you can realize substantial benefits by participating in society-approved insurance plans. Designed and administered by professionals in cooperation with ISMS, this program could be the answer to your personal and professional needs. While your requirements receive individual attention, you also enjoy the economies of ISMS group purchasing power.

COMPLETE PROGRAM PROFILE OFFERED WITHOUT OBLIGATION



ABSTRACTS OF ACTIONS

June 25, 1987 *ISMS Conference Complex*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

INDUCTION OF PRESIDENT

Dr. Edward J. Fesco, LaSalle, was installed as ISMS President, succeeding Dr. Allan L. Goslin, Streator, who died May 3, 1987.

OTHER ACTIONS

In addressing various issues, the Board:

- Directed that the Society continue its educational efforts on contracting issues and institute a $100 per review charge to members seeking review of individual HMO, PPO and IPA contracts, and that after one year the charge be reviewed.
- Discharged the Ad Hoc Committees on Professional Liability Initiatives II and Rewrite of the Medical Practice Act, with commendation.
- Agreed to explore the possibility of assisting in development of an AIDS symposium with Northwestern University, provided there be no cost to ISMS.
- Approved the legislative positions delineated in a primary list of House and Senate bills of interest to ISMS.
- Strongly reaffirmed its previous position to not endorse the contracted community outreach portion of the Healthy Kids program and to communicate its concerns to IDPA.
- Heard a report on a meeting of ISMS and AMA Leadership regarding ISMS Res. 47 (A-87) titled, Responsibility of the "AM News." The resolution asks the AMA to consult with state and local component societies before publishing articles that may have significant state or local implications. The Board agreed to observe "AM News" for changes.
- Accepted the April 30, 1987, Financial Statements; June 10, 1987, IMPAC Collection Data; May 31, 1987, Dues Payment Report; and Requests for Changes in Membership Status.

PROGRAMS/MEETINGS

The Board:

- Approved the following meeting schedule: September 19, 1987; November 6-7, 1987 (All-Member Conference); January 30, 1988; April 21-24, 1988 (Annual Meeting); June 11, 1988.
- Agreed to hold an All-Member Conference November 7, 1987, at the Hyatt Oak Brook Hotel.
- Agreed to hold the 1989 Interim Session/All-Member Conference in Winnebago County at the Clock Tower Inn, Rockford. A meeting site was approved a year ago for a 1988 conference on November 4-5, in Springfield.

NOMINATIONS AND APPOINTMENTS

The Board:

- Ratified appointment of ISMS members to one-year terms on the Society's councils and committees for 1987-88.
- Appointed council chairmen were: Drs. Fred Z. White, Chillicothe, Council on Economics; Boyd McCracken, Sr., Greenville, Council on Education and Manpower; Terry Mason, Chicago, Governmental Affairs Council; Geoffrey Bland, Springfield, Medical-Legal Council; James L. McGee, Decatur, Council on Medical Services; Thomas Minogue, Urbana, Council on Mental Health and Addiction; and Jane Jackman, Springfield, Council on Public Relations and Membership Services.
- Appointed chairmen of committees reporting directly to the Board were: Drs. Donald Pochyly, Hines, Committee on CME Accreditation; Vincent A. Costanzo, Jr., Chicago, Committee on Drugs and Therapeutics; Henrietta Herbolsheimer, Chicago, Committee on Health Planning; L. Michael Newman, Evanston, Committee for the Impaired Physician; and Boone Brackett, Oak Park, Peer Review Appeals Committee.
- Ratified the nominations of: (1) Dr. David Main, Urbana, to serve on the Attorney General's Task Force on Asbestos; and (2) Dr. Charles S. Colodny, Vernon Hills, to serve on the IDPH Radiologic Technology Accreditation Board.
- Approved a roster of physician nominees for submission to the AMA for residency review committees.

INFORMATIONAL REPORTS

Informational reports were presented by the Council on Medical Services, ISMIS, ISMIE, Medical Student Section, Trustees and AMA Delegation Chairman.

NEXT MEETING

The next Board of Trustees meeting was set for September 19, 1987, at ISMS Headquarters.

To show you how many hypertensives stayed on INDERAL® LA (PROPRANOLOL HCl) after a major nationwide trial...




...we had
to find
just the
right room.

60,073 patients (90%) who started on INDERAL LA stayed on INDERAL LA.[1*]

Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

Control, comfort, and compliance

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

NOW AVAILABLE...
NEW LOW DOSE
INDERAL LA 60 mg
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Please see next page for brief summary of prescribing information

The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl)
LONG ACTING CAPSULES



WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) - PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with chilling and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

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MEMBERSHIP FORUM

Membership Forum is intended to serve as a communication tool for ISMS membership. The editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. *The right to edit materials, which should be limited to 300 words or less, is reserved.*

Correspondence should be addressed to: IMJ, Twenty North Michigan Avenue, Suite 700, Chicago 60602.

Correction and Clarification

Editor's Note: Reprinted below is a letter which calls attention to an error in the June issue. We apologize for this oversight and any confusion it may have produced.

Sir:

I write to correct a serious error in your June, 1987 issue. In your editorial preamble to the special article: (Lattimer, A.: "Acquired Immunodeficiency Syndrome: Issues for Hospitals and Medical Staffs," 171:6, 379-381, 1987) reference is erroneously made to "a medical staff decision to limit the privileges of a physician with AIDS," at Cook County Hospital. Just the reverse is true. The unanimous recommendation of the Executive Committee of the Medical Staff, acting for the organized Medical Staff of Cook County Hospital, was *not* to limit the privileges of the physician with AIDS.

The Infection Control Committee at Cook County Hospital had previously adopted the CDC Guidelines relative to health care workers with AIDS (*MMWR:* 34, 681-695, Nov. 15, 1985); their application in this case required precautions that happen to be identical to those recommended by CDC for all health care workers (*MMWR:* 35, 221-223, Apr. 11, 1986). The physician had appropriately informed his division chairman, who in turn had verified the physician's conformity to the CDC Guidelines. The Hospital's board of governors, in this case the Cook County Board of Commissioners, received notice of the physician's diagnosis and ordered the suspension of his clinical privileges including all patient contact. In accordance with the Medical Staff Bylaws the Peer Review Committee then reviewed this action and unanimously recommended the restoration of the physician's clinical privileges. This recommendation was based upon the determination that the nature of his contact with patients did not pose a risk of HIV transmission and upon a monitoring requirement. The Executive Committee of the Medical Staff unanimously adopted this recommendation. In doing so the Executive Committee took full account of the right of patients to "expect reasonable safety insofar as the hospital practices and environment are concerned" (JCAH 1987) and of the right of patients to be informed of the risks in any diagnostic or therapeutic procedures to which they submit themselves. In this context it was believed that patients have an absolute right to expect that physicians will voluntarily inform them of actual risks but not that physicians will voluntarily inform them of imagined risks.

Should a patient indicate any concern about the status of the physician, the care of the patient could be transferred to one of a number of other attending physicians in the same specialty. It is not uncommon at Cook County Hospital for patients to request an attending physician different from the one to whom they are assigned; it is just as possible for them to get a different attending physician at Cook County Hospital as it is at any large private hospital and possibly easier than in small hospitals and in some HMOs.

The governing body did not accept the recommendation of the Medical Staff but the medical staff due process system at Cook County Hospital is such that the physician continued to perform all of his clinical duties pending completion of the process and final action by the Board. At the time of writing (7/20/87) he has been performing his normal clinical duties during the last five months. ◀

Sincerely
Ian Carr, M.D., President
Medical Staff
Cook County Hospital

A Question of Semantics

Editor's Note: In April, 1986, *IMJ* published a guest editorial by Dr. Marc A. Pomerantz, calling attention to the use of the term "client" as a synonym for "patient" in medical circles. Dr. Myers responded to that column with the letter reprinted below; Dr. Pomerantz' reply to her comments follows. Persons seeking the original material which prompted this exchange may refer to *IMJ,* 169:4, 217, April 1986.

Dear Sir or Madam:

Regarding your guest editorial in the April issue dealing with the use of the word "clients":

The article does not appear to support your conclusions. The defi-

nition of patient is "a person who is ill or who is undergoing treatment for disease." If physicians are to deal only with persons fitting into this category, should the thousands of healthy persons who go to doctors for dozens of different reasons seek their health needs from non-physicians?

Examples are myriad; here are a few:

- well babies for check on development
- immunizations for babies, children and adults who are extremely healthy
- physical examinations for children and adults (for school, insurance, etc.)
- preventive check-ups to rule out glaucoma, diabetes, hypertension, etc.)
- contraceptive services for healthy women
- Pap tests for women
- cancer screening programs
- vasectomies and tubal ligations on healthy adults
- elective plastic surgery
- hormone replacement therapy for menopausal women
- and the list goes on and on. . . .

Is Dr. Pomerantz seriously advocating that physicians serve only persons who are ill or undergoing treatment for disease? I would appreciate clarification on what appears to me to be most disturbing. Thank you for your kind consideration. ◂

Sincerely
Lonny Myers, M.D.

Dear Sir or Madam:

I regret that Dr. Myers felt so moved by the apparent omission of certain classes of *patients* that she felt it necessary to write and detail them. Examination of the list shows that most of the types of services that Dr. Myers listed fall into the category of Preventive Medicine and Public Health. Certainly, she would allow prevention and surveillance of both individual and community health as forms of treatment. The problem seems to lie in Dr. Myers' insistence upon a strict, narrow, and individual definition of the words, "treatment" and "disease." Most physicians have long recognized that it is often easier and better to deal with disease before the process becomes flagrant; this may require examination of a person who appears to be well. A person with a perceived cosmetic deformity may feel as ill as someone who has a cold.

The persons who refer to *patients* as *clients* are the same ones who would deny the necessity of a physician performing many of the services that Dr. Myers cited. They claim that an unsupervised nurse or trained technician can perform many of the same services as a physician does for a lesser fee.

Dr. Myers seems to have missed the point of my article, which was that the patient-physician relationship is much deeper and more comprehensive than the mere exchange of a period of time for a sum of money. ◂

Sincerely
Marc A. Pomerantz, M.D.

On Quality of Life

Dear Editor:

Recently our Medical School sponsored a seminar on the ethics of "Do Not Resuscitate" orders that was presented by nationally known experts; a lawyer and a clergyman. The final speaker, the lawyer, ended his presentation with the living will and I pondered on the applications in my life.

Nine years ago I made a compact with a colleague that if either of us was faced with a terminal illness or a vegetative existence the other would visit daily and leave two doses of sleeping pills and then on the last visit leave a bottle of Scotch whiskey. Subsequently, his lymphoma of the stomach was discovered at a distant clinic and he succumbed there so I never had an opportunity to reflect on whether or not to carry out my part of the bargain.

Six and a half years ago I had a myocardial infarction followed by a cerebral vascular accident which left me with a left hemiparalysis. I have often wondered how he would have assessed my state; what action he would have taken. I would have refused any proffered drugs, for just being alive was wonderful. I've had time to get my affairs in order and tell my wife where all the "bones" are buried. My investments were rather untidy as I'm sure most physician's investments are. Now after six and a half years I know she can handle them better than I. I've learned a great deal about my children and their ability to cope with a major crisis. I see they have adjusted very well to it and they gave me untold support during my rehabilitation period, support that has made my adjustment to life as an invalid easy. I know now that they can face any of life's problems with equanimity. I'm mighty proud of them and the capable way in which they are coping with everything. We have adjusted to this and all other phases of our lives and I have taken pleasure in contributing to community activities, traveling by ship, plane and train and we are making preliminary arrangements for a clinical trip to India next year in spite of my hemiplegia. I walk, manage stairs, swim a quarter of a mile three times weekly, enjoy concerts, theatre, Rotary and I haven't turned down a party invitation yet.

Had my pact been binding with the physician friend I would have made a terrible error; the quality of life after a stroke is so much better than I thought it would be. ◂

Sincerely
Hugh A. Johnson, M.D.

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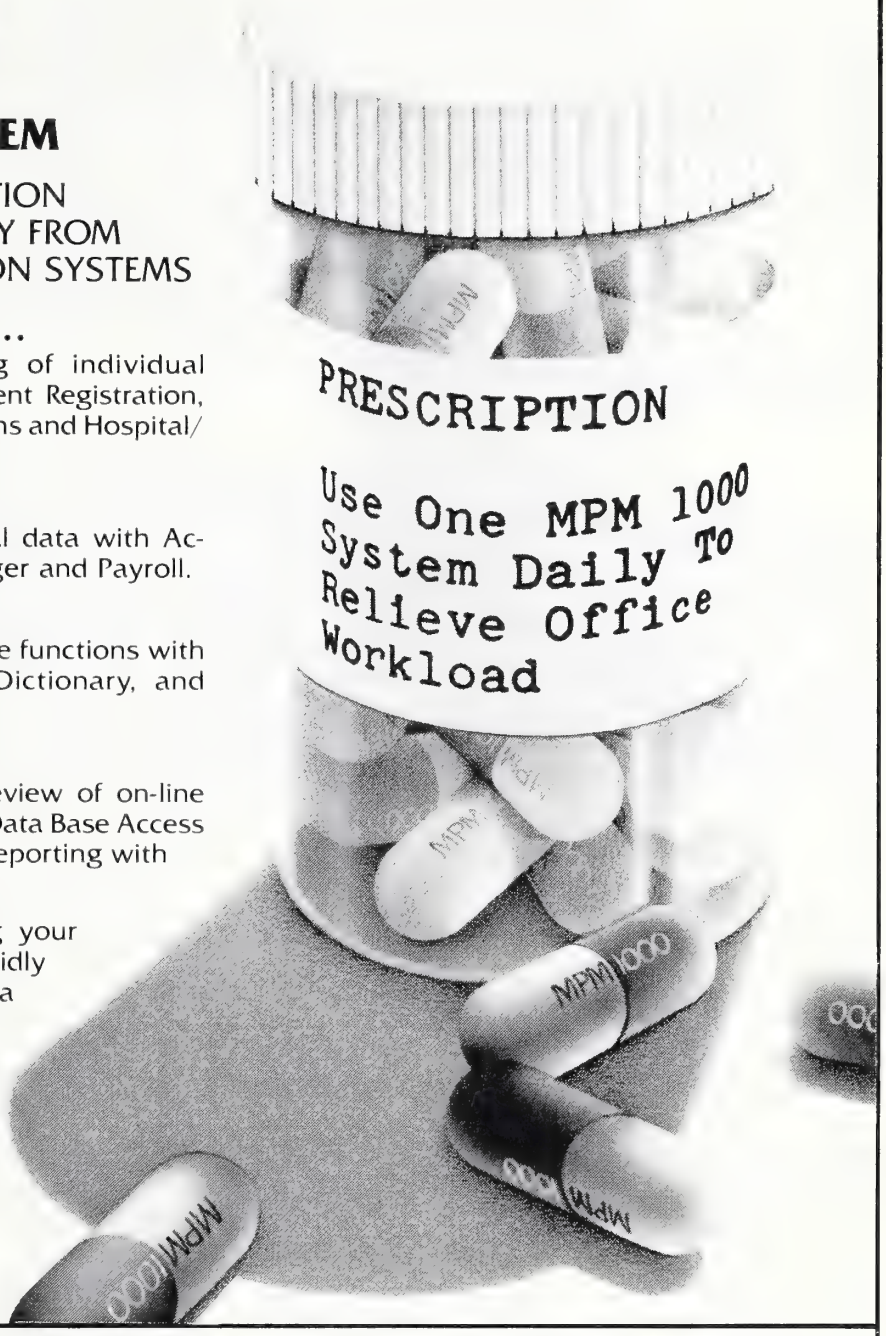
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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Illinois Department of Public Health (IDPH)

Medical Staff Membership

In response to an appeal by the Illinois Psychological Association on May 12, 1987, the U.S. Seventh Circuit Court of Appeals affirmed a lower court decision relating to the Hospital Licensing Act rule defining who can be a member of a hospital medical staff. The rule, made effective June 2, 1987 by the court order, restricts medical staff membership to the categories listed in the following definition:

> "Medical Staff: The term 'medical staff' means an organized body composed of the following individuals granted the privilege by the governing authority of the hospital to practice in the hospital: persons who are graduates of a college or school approved or recognized by the Illinois Department of Registration and Education to practice medicine in all its branches; practice dental surgery or practice podiatric medicine in Illinois, regardless of the title of the degree awarded by the approving college or school."

The new rule was sent to all Illinois hospitals.
(Source: Memorandum to hospitals from IDPH, June 2, 1987)

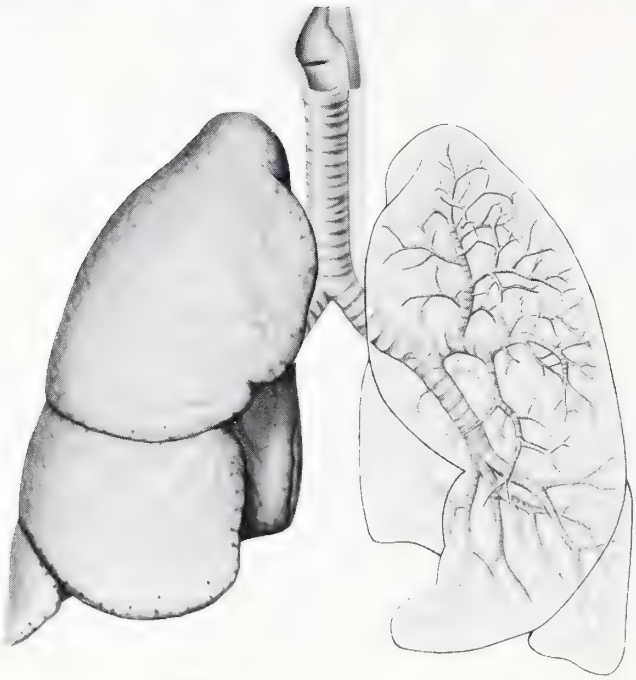
From the Department of Registration and Education (DRE)

Disciplinary Orders

- *Norberto T. Agustin* (Lic. # 036-048618 & 003-036-048618-1)
  Effective May 21, 1987, Dr. Agustin's medical license was revoked for a minimum of 2 years and his controlled substance license was revoked for a period of not less than 2 years.
- *Budris Andernovics* (Lic. # 036-032709 & 003-036-032709-1)
  Effective May 1, 1987, Dr. Andernovics' controlled substance license was placed on probation for one year.
- *Paul W. Clark* (Lic. # 036-030730)
  Effective April 22, 1987, Dr. Clark's medical license was indefinitely suspended.
- *John Familaro* (Lic. # 036-032059)
  Effective May 21, 1987, Dr. Familaro's medical license was placed on inactive status.
- *Marlow R. Harston* (Lic. # 036-028005)
  Effective April 22, 1987, Dr. Harston's medical license was reinstated, subject to an indefinite period of probation and certain conditions.
- *Joel M. Levin* (Lic. # 036-035220)
  Effective February 10, 1987, Dr. Levin's medical license was suspended for 9 months.
- *Arthur R. Marks* (Lic. # 003-036-025604-1)
  Effective May 4, 1987, Dr. Marks' controlled substance license was fully restored.
- *Arthur A. Polussa* (Lic. # 036-066885 & 003-036-066885-1)
  Effective June 1, 1987, Dr. Polussa's medical license was suspended for 3 months and following that time, his license will be on probation for 3 years. His controlled substance license was suspended for 1 year and following that time, it will be placed on a 2 year probation.
- *Donald H. Rames* (Lic. # 003-036-034122-1 & 036-034122)
  Effective May 21, 1987, Dr. Rames' controlled substance license was placed on probation for one year.
- *Vincent J. Renzino* (Lic. # 036-022919)
  Effective April 22, 1987, Dr. Renzino's medical license was suspended for 90 days beginning June 1, 1987 and placed on indefinite probation thereafter.
- *Eladio E. Vazquez* (Lic. # 036-035907 & 003-036-035907-1)
  Effective April 27, 1987, Dr. Vazquez's medical license was indefinitely suspended for a minimum of 3 years and his controlled substance license was revoked for a minimum of 5 years.
- *Russell J. Wood* (Lic. # 036-039598 & 003-036-039598-1)
  Effective May 11, 1987, Dr. Wood's medical and controlled substance licenses were indefinitely suspended.

(Source: Orders received from DRE)

Consider the causative organisms...



Ceclor® cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, Streptococcus pneumoniae
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci)

Contraindication:
Known allergy to cephalosporins

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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IMJ

Illinois Medical Journal
Illinois State Medical Society

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In a Midwestern American Population

Cervical Microflora of Pelvic Inflammatory Disease

By Paul S. Heckerling, M.D., Constance Catellani, M.D., Alan A. Harris, M.D., Lawrence Goodman, M.D., and Robert Patterson/Chicago

In order to identify the frequency of Neisseria gonorrhoeae, Chlamydia trachomatis, Mycoplasma hominis, *and* Ureaplasma urealyticum *in women utilizing an emergency room in the Midwest, we obtained endocervical cultures for these organisms from all women eighteen years or older who received a pelvic examination. Culture results were compared between women clinically diagnosed as having pelvic inflammatory disease and those with other diagnoses. Of 159 patients evaluated, 24 had pelvic inflammatory disease, and 135 had other gynecologic and non-gynecologic problems.* Mycoplasma hominis *was isolated in 56.5% with, and 30.9% without pelvic inflammatory disease, and was the only organism significantly more common in the group with pelvic infection ($p < .05$). Unlike other populations,* Neisseria gonorrhoeae *and* Chlamydia trachomatis *were infrequent isolates in patients with pelvic inflammatory disease, being found in only 21.7% and 8.7%, respectively.*

The microbial etiology of acute salpingitis varies depending upon geographic location.[1,2] In North American patients with pelvic inflammatory disease, *Neisseria gonorrhoeae* and mixed anaerobic and aerobic bacterial species were isolated in studies from Washington,[3] whereas *Chlamydia trachomatis* was found in British Columbia.[4] In Swedish patients with salpingitis, *Chlamydia trachomatis*[5] and *Mycoplasma hominis*[6] were isolated most frequently.

To identify the microbial agents of pelvic inflammatory disease indigenous to a midwestern American population, we studied the endocervical microflora of patients who presented to our emergency room with acute salpingitis.

Methods

All female patients aged 18 or older who were seen in our emergency room over a one-month period and received a pelvic examination as part of their medical evaluation were studied. Information was collected by chart review on clinical diagnosis. Noted was the presence or absence of symptoms of abdominal pain and signs of fever (temperature >100°F), tenderness on cervical motion, adnexal tenderness, and vaginal discharge.

Patients were classified as having pelvic inflammatory disease (PID) based on the clinical impression of the examining physician and if they met each of the following three criteria: (1) a history of low abdominal pain; (2) cervical motion tenderness and (3) adnexal tenderness.

Endocervical cultures for *N. gonorrhoeae, C. trachomatis, M. hominis,* and *U. urealyticum* were performed on all patients. Two specimens for cervical cultures were obtained sequentially with calcium alginate swabs. Cultures for *N. gonorrhoeae,* obtained from the first swab, were immediately plated onto Thayer-Martin medium, incubated at 35°C in a candle jar, and transported to the Board of Health. Cultures for chlamydia and mycoplasmas, obtained from the second swab, were inoculated into Hank's balanced salt solution supplemented with 1% bovine serum albumin and titrated to neutral pH with 7.5% sodium bicarbonate. Cultures for *C. trachomatis* were centrifuged onto idoxuridine or cycloheximide-treated McCoy cells. Infection was confirmed

by microscopic evidence of inclusion bodies by iodine stain and/or by an indirect immunofluorescent antibody test using antichlamydial antibodies.[7] Negative specimens were subcultured once before being reported. Cultures for mycoplasmas were plated on the following media: (1) *M. hominis:* phenol red arginine biphasic medium and arginine agar, pH 7.0; (2) *U. urealyticum:* phenol red, urea broth and urea agar, pH 6.0. All specimens were incubated at 35.0° ± 0.5°C in a 5%-10%CO, 95%-90% aerobic atmosphere for four to six weeks. Subcultures of negative specimens were performed weekly. Growth inhibition tests were used to identify unknown specimens.[8]

Statistical significance was determined by chi-square analysis using Yates' correction.

Table 1
Clinical Findings in Patients With and Without Pelvic Inflammatory Disease

Clinical Signs	Patients With PID (% of Total)	Patients Without PID (% of Total)	Level of Statistical Significance
Fever (temp >100°F)	2 (8.3)	11 (8.1)	p = n.s.*
Cervical motion tenderness	24 (100)	20 (14.8)	p < .001
Adnexal tenderness	24 (100)	34 (25.2)	p < .001
Vaginal discharge	8 (33.3)	43 (31.9)	p = n.s.

*at an alpha level of .05.

Table 2
Cervical Cultures in Patients With and Without Pelvic Inflammatory Disease

Micro-Organism	Patients With PID (% of Total)	Patients Without PID (% of Total)	Level of Statistical Significance
Neisseria gonorrhoeae	5/23* (21.7)	9/118 (7.6)	p = n.s.**
Chlamydia trachomatis	2/23 (8.7)	7/123 (5.7)	p = n.s.
Mycoplasma hominis	13/23 (56.5)	38/123 (30.9)	p < .05
Ureaplasma urealyticum	8/23 (34.8)	34/123 (27.6)	p = n.s.

*denominator indicates number of patients for whom culture results were available
**at an alpha level of .05

Results

Twenty-four patients satisfied the clinical criteria for pelvic inflammatory disease. A total of 135 patients were clinically diagnosed as having other gynecologic and non-gynecologic problems. The two groups were comparable with regard to age (mean ages: 23.8 and 25.6 years, respectively), race (both 92% black), and residence (100% and 99% Chicago residents, respectively) (p = n.s.).

Clinical characteristics of patients with and without pelvic inflammatory disease are shown in Table 1. Cervical motion tenderness and adnexal tenderness were both found in 100% of patients with pelvic inflammatory disease (as a result of selection criteria for PID), but in only 15% and 25%, respectively, of patients without pelvic inflammatory disease (p < .001). Vaginal discharge was found in 33% with, and 32% without pelvic inflammatory disease (p = n.s.). Fever occurred in only 8% of patients both with and without pelvic infection (p = n.s.). Of the patients with pelvic inflammatory disease, eighteen (75%) were considered to have mild to moderate disease and were treated as outpatients, while six (25%) had disease severe enough to require hospitalization.

Results of cervical cultures are shown in Table 2. *M. hominis* was isolated in 57% of patients with, and 31% without pelvic inflammatory disease (p < .05). *U. urealyticum* was isolated in 35% with, and 28% without pelvic infection (p = n.s.). *C. trachomatis* was isolated infrequently, being found in only 9% of patients with, and 6% without pelvic inflammatory disease (p = n.s.). Similarly, *N. gonorrhoeae* was isolated infrequently, in 22% with, and 8% without pelvic inflammatory disease (p = n.s.).

There were 21 patients in whom the examining physician's clinical impression was pelvic inflammatory disease, but who did not meet the other criteria for that diagnosis. These patients were comparable to the others with regard to age (mean age: 23.0 years), race (95% black) and residence (100% Chicago) (p = n.s.). Had these patients been included among the cases of pelvic inflammatory disease, the culture results among patients with pelvic infection would have been as follows: *M. hominis,* 47% (p < .1, compared with patients without pelvic infection); *U. urealyticum,* 33% (p = n.s.); C. *trachomatis,* 7% (p = n.s.); and *N. gonorrhoeae,* 16% (p = n.s.).

Discussion

In patients with pelvic inflammatory disease in a midwestern American city, *M. hominis* was the organism most commonly isolated from endocervical cultures. *M. hominis* was found in 57% of patients with, and 31% without clinically diagnosed salpingitis (p < .05), suggesting a possible association between this organism and pelvic infection. The relationship between acute salpingitis and mycoplasmal infection has been studied by others.[3,6,10] In patients with clinically diagnosed salpingitis in Seattle, Eschenbach[3] found *M. hominis* in endocervical isolates of 72% of patients with, and 60% without pelvic inflammatory disease (p < .025), but could not isolate the organism from cul-de-sac peritoneal fluid. Sweet[10] found that

in a San Francisco population with laparoscopically-verified tubal inflammation, *M. hominis* was isolated from the endocervix in 73%, but from the cul-de-sac in only 4%, and from the fallopian tubes in none. In studies from Sweden, Mardh[6] isolated *M. hominis* from the cervices of 62% of patients with laparoscopically-verified salpingitis, 46% of patients with cervicitis, but only 4% of non-infected controls. In addition, *M. hominis* was isolated from the fallopian tubes of four patients with salpingitis, but in none of those with cervicitis or without lower genital tract infection. In patients with salpingitis from whom *M. hominis* was isolated from the fallopian tubes, the titer of indirect hemagglutinating antibody to the organism rose significantly during the course of the disease.[12] Although the isolation of mycoplasma from fallopian tubes suggests an etiologic role in acute salpingitis, the high endocervical but very low tubal and peritoneal isolation rates found in all these studies suggest that this organism may simply be a lower genital tract commensal in sexually active populations.

U. urealyticum was isolated in 35% of patients with, and 28% without salpingitis (p = n.s.). These results are similar to those of others,[3,6] who found no significant differences in the frequencies of endocervical ureaplasmal colonization in patients with and without pelvic inflammatory disease. Although this suggests that T-mycoplasmas are probably lower genital tract commensals, *U. urealyticum* in pure culture has been isolated from the fallopian tubes of two patients with laparoscopically-documented salpingitis,[6] raising the possibility of an etiologic role in some cases of pelvic infection.

In this population, *C. trachomatis* was isolated infrequently: in only 9% of patients with, and 6% without salpingitis. These low chlamydial isolation rates are similar to those in several studies of pelvic inflammatory disease in North American populations.[10,11] They differ markedly, however, from the 51% isolation rate for *C. trachomatis* in patients with salpingitis from a British Columbian population with an endemic endocervical carriage rate for chlamydia of 22%.[4] They also differ from the results of Swedish studies, in which 36% of those with salpingitis, but zero percent of controls grew *C. trachomatis* from cervical cultures, and the organism could be cultured from fallopian tubal exudates.[5] Thus, although *C. trachomatis* may cause salpingitis in certain populations, it did not appear to be an important cause of pelvic infection in our patients.

N. gonorrhoeae was cultured from 22% of patients with salpingitis and 8% without pelvic infection, a difference that was not statistically significant. These results contrast with gonococcal isolation rates of 35%,[4] 44%,[3] 50%,[10] and 80%[11] in patients with salpingitis from other parts of North America. It is also of interest that a neighboring hospital serving a similar patient population reported a 34% gonococcal isolation rate in hospitalized patients with pelvic inflammatory disease.[13] These patients had evidence of severe infection, with an almost 50% incidence of peritonitis and/or tubo-ovarian abscess. Comparison of results supports previous suggestions that gonococcal salpingitis tends to be a more severe disease clinically than salpingitis of other etiologies.[14,15] Although only one of our five hospitalized patients for whom cultures were available grew *N. gonorrhoeae,* this small sample size precludes meaningful conclusions on the prevalence of gonococcal salpingitis in these patients.

The clinical and microbiological evaluation of pelvic inflammatory disease in an outpatient population presents several difficulties. Although clinical findings of cervical motion tenderness and bilateral adnexal tenderness suggest salpingitis as an etiology of pelvic pain, laparoscopy may reveal other pathologic conditions or no pathologic changes in up to 35% of patients.[9] In addition, laparoscopic evidence of acute salpingitis, such as tubal hyperemia, edema, and exudate, may be found in patients whose clinical signs suggest other diagnoses.[9] Since laparoscopic inspection of the fallopian tubes is not feasible in outpatients with mild to moderate disease, diagnostic ambiguities will remain unavoidable in these patient populations. There are also ambiguities attendant upon the use of endocervical cultures to define the microbial etiology of pelvic inflammatory disease. Although tubal infection is presumed to be caused by ascent of lower genital tract organisms, endocervical isolates have not always corresponded with isolates from tubal exudate[10] or cul-de-sac fluid.[10,11] Endocervical cultures also preclude evaluation of the role of anaerobic organisms in pelvic infection. However, cul-de-sac cultures, while providing material suitable for anaerobic studies, also do not correlate well with tubal isolates.[10] In addition, they involve some patient discomfort, and are therefore unlikely to replace endocervical cultures in the evaluation of outpatients with pelvic inflammatory disease.

In conclusion, in a midwestern American emergency room population with clinical salpingitis, *M. hominis* was the organism most commonly isolated, and the prevalence of *N. gonorrhoeae* and *C. trachomatis* were low. Based on this microbiologic information and expected antimicrobial susceptibility patterns, treatment of such patients with tetracycline antibiotics would seem prudent. Whether such treatment would confer any advantage over traditional anti-gonococcal regimens containing penicillin or its congeners in shortening the course of pelvic infection or preventing its long term complications remains to be determined. ◀

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Advances in Operative Treatment

Localized Prostatic Cancer

By Jackson E. Fowler, Jr., M.D., Michael Clayton, M.D., Roohollah Sharifi, M.D., Konda Mouli, M.D., Larry Ojeda, M.D., And Paul S. Ray, D.O./Chicago

Operative, postoperative and late complications of pelvic lymphadenectomy and radical retropubic prostatectomy are analyzed in 35 consecutive cases where the modifications of prostatectomy described by Walsh were employed. All patients had clinical Stage A_2, B_1 or B_2 tumors and no histologically identifiable pelvic lymph node metastases. There were no postoperative deaths. Seven patients (20%) experienced a total of eight significant postoperative complications. Ninety-seven percent of evaluable patients were completely continent following surgery. Erectile function satisfactory for intercourse was preserved in 88% of evaluable patients who were potent before surgery. We are persuaded that innovations of radical retropubic prostatectomy detailed by Walsh constitute important advances in surgical technique. We employ this procedure for localized prostatic cancer in all suitable patients electing treatment by radical prostatectomy.

Adenocarcinoma of the prostate is the second most common malignancy and the third leading cause of cancer deaths among males in the United States. No curative treatment has been found for prostatic tumors that have metastasized to distant sites, and the prospect for cure among patients with regional lymph node metastases is limited.[1,2] Detection and ablation of the primary tumor before dissemination constitute the only reasonable hope for decreasing the morbidity and mortality associated with this cancer.

Radiation therapy delivered by external beam, interstitial implantation, or a combination of the two may be effective for local control and eradication of many primary tumors.[3-5] Removal of the prostate and adjacent seminal vesicles is also curative in a large proportion of selected patients with localized tumors.[6-9] However, due to the technical difficulties of radical prostatectomy, and anticipated impotence and possible incontinence resulting from the intervention, enthusiasm within the urologic community for this treatment has been limited.

During the past decade, Walsh and associates have systematically investigated the periprostatic neural and venous anatomy of the male[10,11] (Figure 1). Insights from these studies have led to modified retropubic techniques for removal of the prostate and seminal vesicles. These modifications have simplified the procedure, decreased the risks of intraoperative hemorrhage and reduced the possibility of postoperative incontinence and impotence.

Two technical maneuvers developed by Walsh are particularly noteworthy. The first involves ligation and transsection under direct vision of the entire dorsal venous complex overlying the apex of the prostate.[10] (Figure 2) This predictably effective technique for handling a fragile, deep-seated venous complex markedly reduces the likelihood of difficult-to-control venous bleeding, and facilitates division of the urethra at the apex of the prostate. The second maneuver involves ligation of the vascular supply of the prostate immediately adjacent to the prostatic capsule.[12,13] (Figure 3) This is based upon findings that the autonomic nerves necessary for physiologic erection course from the pelvic plexus posterolateral to the pros-

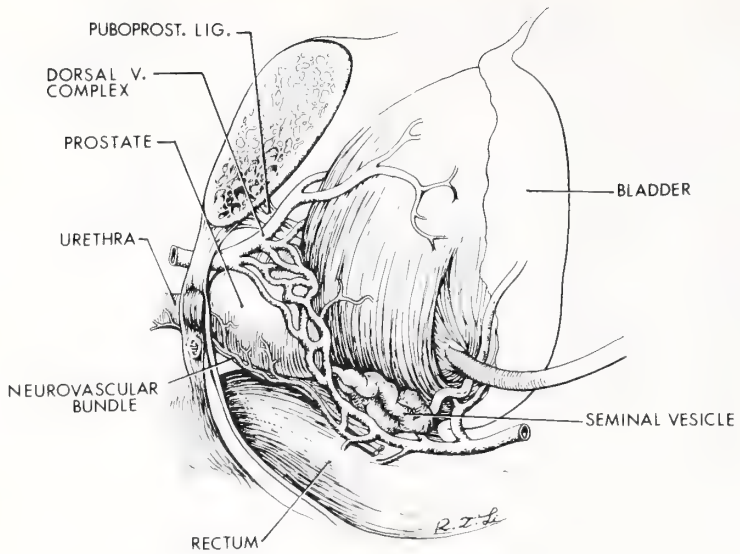


Figure 1
Periprostatic neural and avascular anatomy as described by Walsh, et al. Note that the dorsal venous complex overlying the apex of the prostate is well defined and compact. The autonomic nerves required for physiologic erection course posterolateral to the prostate, and are accompanied by arteries and veins from which the lateral vascular pedicles of the prostate emanate.

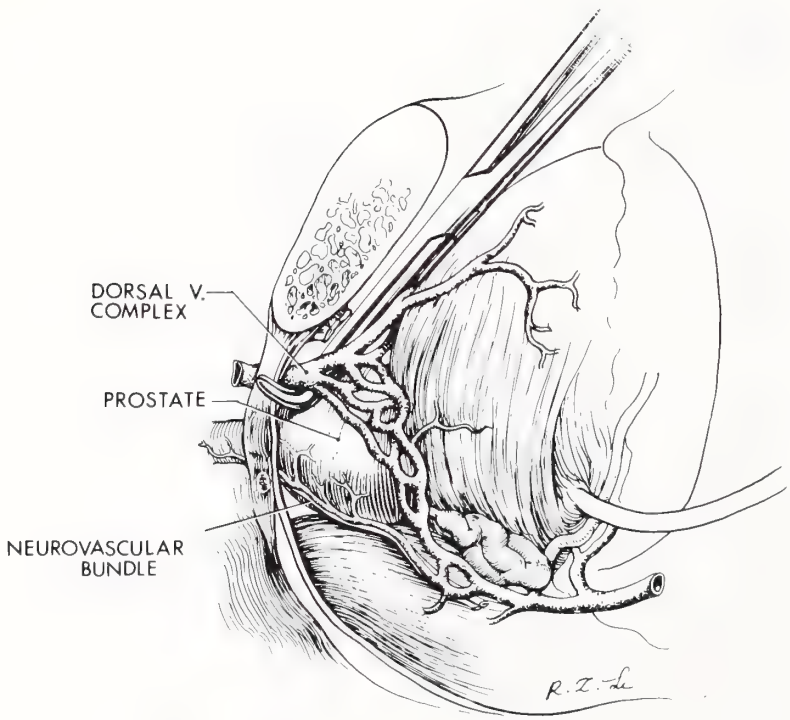


Figure 2
Maneuver for isolation of dorsal venous complex after transection of the puboprostatic ligaments. A large right angle clamp is passed under the venous complex at the apex of the prostate, and a ligature is tied around the complex to prevent venous hemorrhage following transection.

tate in neurovascular bundles. This maneuver prevents inadvertent damage to the neurovascular bundles, and preserves erectile function in approximately 80% of patients.[14,15]

This report reviews recent experience with the Walsh technique of radical retropubic prostatectomy.

Materials and Methods

Forty-seven patients with biopsy-proven adenocarcinoma of the prostate were evaluated for radical retropubic prostatectomy. All had primary tumors that appeared to be confined to the prostate on digital examination, normal serum acid phosphatase levels and normal bone scans. Each had an anticipated life expectancy of greater than five years, accepted potential surgical risks and was judged suitable for major surgery.

An extraperitoneal pelvic lymphadenectomy was performed immediately prior to anticipated radical prostatectomy. The excised lymphatic tissues were examined with frozen section techniques. Surgery was aborted in 11 cases because of identifiable lymph node metastases, and alternative treatment with radiation therapy or androgen deprivation was recommended.

Of the remaining 36 patients, 35 underwent radical retropubic prostatectomy using the modifications suggested by Walsh. The mean age was 67 years (range: 55-78). Eight of these 35 patients (23%) had Stage A_2 tumors (clinically undetectable carcinoma involving more than 5% of the prostatic tissue removed for treatment of symptomatic bladder outlet obstruction); 14 (40%) had clinical Stage B_1 tumors (palpable induration confined to one lobe of the prostate); and 13 (37%) had clinical Stage B_2 tumors (palpable induration confined to the prostate but involving one entire lobe or both lobes).

The pathologic stage and histologic grade of the primary tumors were assessed by staff pathologists. Two pathologic stages were recognized: (1) Disease confined to the prostate (tumors confined to the parenchyma of the prostate or those that invaded but did not penetrate the capsule of the prostate); and (2) Extracapsular extension (tu-

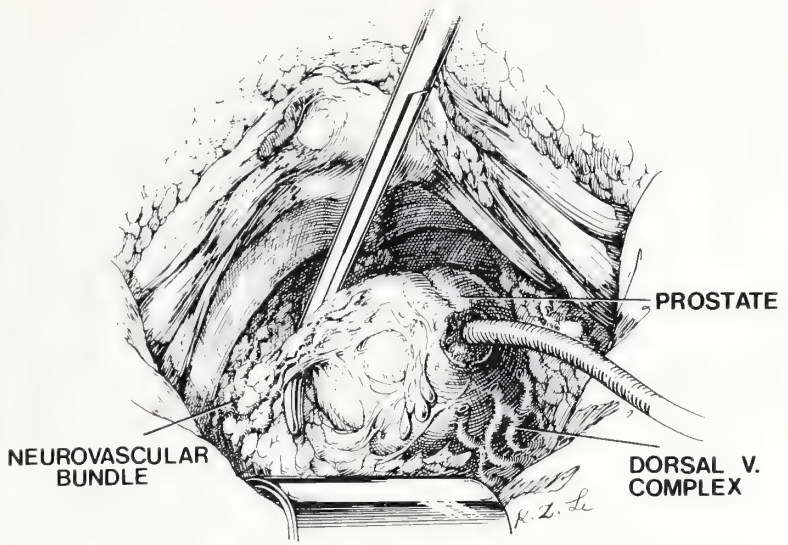


Figure 3
Maneuver for the "nerve sparing" division of the lateral vascular pedicle of the prostate. The urethra at the apex of the prostate has been transected, and the prostate has been mobilized off the rectum and retracted to the contralateral side with a Foley catheter. Note that the vascular branches to the prostate are mobilized so that their division and ligation can be accomplished without damage to nerves in the adjacent neurovascular bundle.

mors with microscopically verified penetration through the prostatic capsule or with seminal vesicle invasion).

Tumor grade was classified as well, moderate or poorly differentiated based upon cytologic characteristics.

All patients have been followed prospectively at 2-4 month intervals. Mild postoperative stress incontinence was defined as incontinence persisting for longer than six months, but requiring no more than one or two protective pads per day. Potency was defined as erectile function sufficient for vaginal penetration and satisfactory intercourse, and was determined by detailed history. Preservation of erectile function was assessed only among patients who had been followed for longer than three months after surgery.

Results

Operative Experience and Postoperative and Late Complications

The operative time (interval between incision and closure) ranged from 2.7 to 6 hours (mean 4.3 hours). Estimated blood loss ranged from 400 to 2,600ml (mean 1029 ml).

There were no postoperative deaths, although one patient suffered an acute cerebrovascular accident on the seventh postoperative day resulting in significant residual neurologic deficits. Six other patients experienced a total of seven significant postoperative complications. Four developed lymphoceles that were treated successfully without surgery, two had prolonged extravasation (more than 21 days) at the urethro-vesical anastomosis, and one patient developed deep vein thrombophlebitis.

Postoperative urinary function was evaluable in 31 patients. Thirty (97%) have remained totally continent and one (3%) has experienced mild, but apparently permanent, stress urinary incontinence.

Postoperative erectile function was evaluable in 17 patients who were potent before surgery. Fifteen (88%) had recovery of erectile function at 1-6 months following surgery.

Histopathologic Findings

No regional lymph node metastases were uncovered on permanent sections of any patient with negative frozen section examinations. Relationships between the clinical and pathologic stages of the tumors are shown in Table I. Extracapsular extension was more frequently associated with clinical Stage B_2 tumors than with clinical Stage B_1 tumors, and Stage B_1 tumors more than with Stage A_2 tumors. Eleven (31%) of the tumors were well differentiated, 23 (66%) were moderately differentiated and one (3%) was poorly differentiated.

Discussion

This experience supports the concept that autonomic nerves which course from the pelvic plexus posterolateral to the prostate are necessary for physiologic erectile function. It also confirms the observations of Walsh[14] and Catalona and Dresner[15] that potency following radical retropubic prostatectomy

Table 1
Relationships Between Clinical and Pathologic Stages of Tumors

Pathologic Stage	Clinical Stage		
	A_2	B_1	B_2
Disease confined to prostate			
No capsular invasion	6	6	4
Capsular invasion	1	4	3
Extracapsular extension			
Capsular penetration only	1	1	0
Seminal vesicle invasion	0	3	6

can usually be preserved if inadvertent injury to these nerves is avoided. The 10%-20% incidence of postoperative impotence in this series and others[14,15] compares favorably with the 20%-50% incidence following external beam radiation therapy,[3] and the 5%-10% incidence following interstitial radiation therapy.[16] Potency following this operation appears to be more likely among patients under age 60.[14,15] Walsh has also reported an inverse correlation between advancing clinical and pathologic stage and the likelihood of preservation of sexual function.[14] Our experience is as yet too limited to corroborate these findings.

We have been impressed also with the relative ease of radical retropubic prostatectomy using the systematic approach described by Walsh, and are encouraged by the extremely low rate of postoperative incontinence (3%). The latter parallels the 3%-5% incidence of urinary incontinence following external beam radiation therapy[3] or interstitial radiation therapy.[16]

The primary objective of radical prostatectomy is to excise completely all malignant tissue. It is logical to believe that preservation of the autonomic nerves posterolateral to the prostate might compromise the therapeutic intent of the operation. However, in a detailed histologic investigation of 100 consecutive patients, Eggleston and Walsh found that 41 had tumor extension into the periprostatic tissues, but that in no case were the surgical margins positive only at the posterolateral aspect of the prostate.[17] Catalona and Dresner compared the pathology of 52 prostatic tumors removed by the "nerve sparing" technique to that of 25 tumors removed by conventional retropubic techniques. The frequency of positive surgical margins was nearly identical in the two groups. In our series only two specimens (6%) were associated with tumor penetration of the prostatic capsule in the absence of seminal vesical invasion. In theory, they would be considered at risk to inadequate excision due to preservation of the neurovascular bundles. Therefore, from a histologic standpoint it seems unlikely that the therapeutic outcome of patients treated by the "nerve sparing" technique would differ from that of patients treated by conventional retropubic procedures. Long term postoperative observation, however, is necessary to substantiate these tentative impressions.

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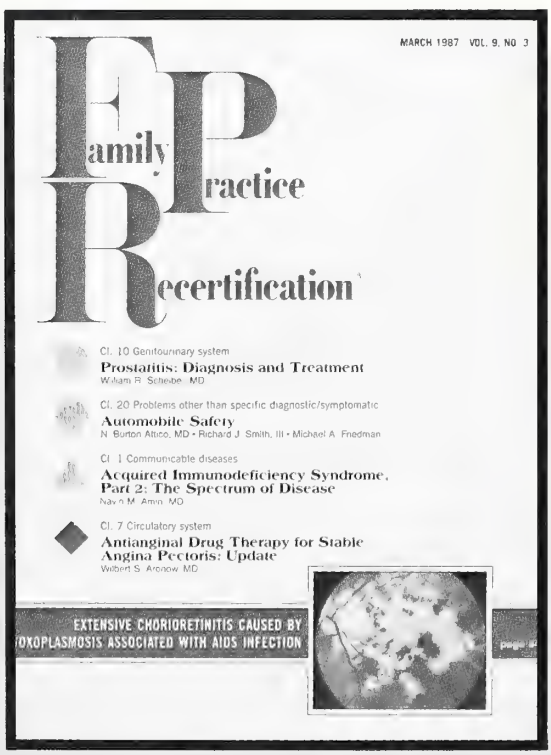
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SPECIAL ARTICLE

Educational Materials Available to Members

In a continuing effort to make ISMS members knowledgeable about current medical issues, the Society has developed a series of new educational materials on AIDS, substance abuse and child abuse. All materials are available from ISMS at no cost to the requesting physician.

AIDS

A packet of materials on AIDS will be sent to every ISMS member. The packet will include a number of documents covering the diagnosis, transmission and prevention of AIDS and HIV. Information on counseling various types of patients, precautions for physicians and other health professionals and an AIDS resource directory are also included.

An audiotape, with AIDS experts discussing many of these subject areas, is available upon request.

The AIDS packet and audiotape are products of a grant from the Illinois Department of Public Health.

Substance Abuse

Prescribing, Dispensing and Administering Controlled Substances

A brochure on prescribing, dispensing and recordkeeping of controlled substances has been produced and distributed to all primary care physicians. The booklet covers such topics as recognizing the abuse-prone patient, taking a drug use history, patient "hustlers," drug diversion techniques, and proper prescribing habits. Additional information on federal and state recordkeeping and security requirements is also provided. An audiotape discussion of these topics by drug abuse experts is available upon request.

Diagnosis and Treatment of Cocaine Addiction

A second new audiotape deals with diagnosis and treatment of cocaine addiction. This tape is part of a series of "Conversations About Drug Abuse" developed by the ISMS Ad Hoc Committee on Substance Abuse Education. The tape is available upon request.

The brochure and audiotapes were developed under a grant from the Department of Alcoholism and Substance Abuse.

Child Abuse

The ISMS has produced five products related to child abuse and neglect under a grant from the Department of Children and Family Services.

DCFS Protocols

The Department asked ISMS to produce and distribute two documents developed under previous grants. Protocols on child abuse autopsies and recognition of child abuse injuries are being sent to hospitals and appropriate specialists. Anyone interested in these documents may receive a copy by writing to ISMS.

Dealing with the Disabled Infant

The ISMS Ad Hoc Committee on Child Abuse Education has created a brochure on handling cases of infants with life-threatening, handicapping conditions. State law and the medical response system are described. This brochure is being sent to all primary care physicians and hospitals.

Child Abuse and Neglect: The Physician's Role

A second booklet on child abuse and neglect offers advice on diagnosis, treatment and reporting of child abuse and neglect. It provides definitive information in each of these areas. This booklet has been sent to hospitals and primary care physicians. Child abuse experts discuss these issues on a supplemental audiotape, which is available on request.

All materials were developed under a grant from the Department of Children and Family Services.

Closing a Medical Practice

The ISMS Medical-Legal Council has developed a booklet designed to assist spouses and family members of deceased physicians who are faced with the task of closing a medical practice unexpectedly.

The brochure outlines steps to advise and help patients make a transition to a new physician. Confidentiality of medical records, disposal of prescription pads and medications on the premises, notification of the malpractice insurer and other entities with legal ties to the practice and dissolution of a medical corporation are among the topics considered.

Other ISMS Materials and Programs

ISMS has developed a number of other educational materials on related topics, such as pediatric substance abuse, drug diversion, the role of the physician in recognizing substance abuse, and physician impairment. In addition, CME seminars on each of these topics have been developed for county society or medical staff presentations.

For further information on or to order any of the above materials or programs, write or call the ISMS Division of Educational and Medical Services, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602; 312-782-1654. ◂

Oculodento-osseous Syndrome in a Newborn Infant

By Julio M. Pardo, M.D./Springfield

Disorders of morphogenesis, although individually rare as a group, are not uncommon. Approximately 0.7% of newborn infants have multiple malformations. Physicians taking care of newborns and children should familiarize themselves with early identification of morphogenic defects, since experience has shown that, with the help of appropriate reference atlases and compendia, the primary physician can often correctly diagnose a malformation syndrome.

The oculodento-osseous (ODO) syndrome was first described by Lohmann[1] in 1920. Subsequently, Gorlin, *et al.*,[2] provided further delineation of the syndrome in 1963. Characteristic ODO syndrome features include thin nose, hypoplastic alae nasi, narrow nostrils, microcornea, enamel hypoplasia, syndactyly and camptodactyly of the fourth and fifth fingers. Occasionally, patients may present with small palpebral fissures, epicanthal folds, microdontia or hypodontia. The hair may be fine, dry and lusterless.[3,4] Intelligence is normal.[3]

A case of ODO syndrome in a newborn infant is reported here to emphasize the importance of early recognition of distinguishing morphologic features present at birth.



Figure 1
Shown are characteristic facial features (bilateral epicanthal folds, thin nose, hypoplastic alae nasi and narrow nostrils) and bilateral cutaneous syndactyly of the third, fourth and fifth fingers.

Case Report

The patient was a white male, the product of a full term, uncomplicated pregnancy and vaginal delivery. Birth weight was 3.1kg and length was 50 centimeters. Apgar scores were 8 and 10 at 1 and 5 minutes, respectively. The mother was 33 years old, gravida 4, para 3, and had not been exposed to any teratogen during the pregnancy. The father was 36 years old and in good health, as were the patient's 4 and 3 year old brothers and a 2 year old sister.

At birth the patient was noticed to have bilateral cutaneous syndactyly of the third, fourth and fifth fingers, and bilateral camptodactyly of the fifth fingers. There was also cutaneous syndactyly of the third and fourth toes bilaterally. Under closer examination other dysmorphic features became noticeable: thin nose with hypoplastic alae nasi, narrow nostrils and bilateral epicanthal folds. (Figure 1) Radiographs of the hands showed bilateral absence of the middle phalanx of the third, fourth and fifth fingers, as well as hypoplasia of the distal phalanx of the right second through fifth fingers.

Literature review of those syndromes featuring syndactyly and hypoplastic alae nasi[3] suggested that the most likely diagnosis in this patient was ODO syndrome. Since the absence of the middle phalanx of the second through fifth toes bilaterally is a constant and characteristic feature of this syndrome,[5,6] the radiographs of the feet were

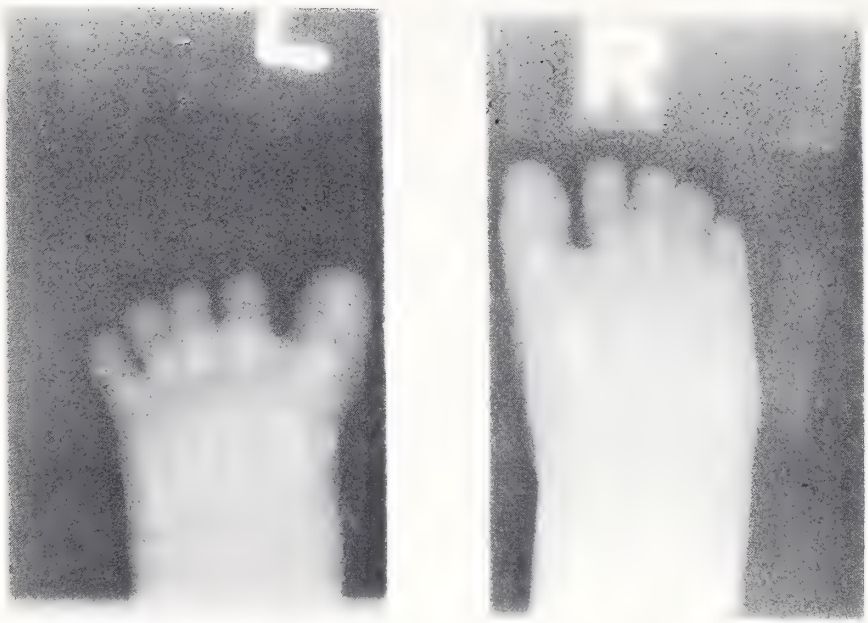


Figure 2
Shown are bilateral cutaneous syndactyly of the third and fourth toes and absence of the middle phalanx of the second through the fifth toes bilaterally.

reviewed. These showed that the middle phalanges of the toes were absent. (Figure 2) Ophthalmological examination confirmed the initial impression of microcornea and microphthalmos, also features of this condition.

On the basis of these findings, the diagnosis of oculodento-osseous syndrome was felt to be established. Physical examinations of members of the patient's immediate family failed to reveal any presence of this condition.

Discussion

Although disorders of morphogenesis are individually rare, as a group they are not uncommon. In fact, approximately 0.7% of newborn infants have multiple malformations.[3] The importance of considering a dysmorphic syndrome can not be overemphasized, because it may allow the physician to establish the diagnosis, give prognosis, provide management plans for the patient, and give genetic counseling to parents. Accordingly, the physicians who take care of newborn infants and children should be able to recognize the presence of morphogenic defects early in life. There are instances in which the primary physician, with the help of appropriate reference atlases and compendia,[3-5,7] can make the correct diagnosis of a malformation syndrome. In a sizeable number of uncomplicated genetic conditions the nonspecialized physician can give useful advice,[8] avoiding the expenses of unnecessary consultations. It has been shown that, even in those cases in which specific therapy is not available, early identification of the child's dysmorphology syndrome will greatly alleviate parents' anxiety, and in some instances may avoid multiple physician visits in search of diagnosis and therapy. In cases of multiple malformations in which the diagnosis of a specific syndrome can not be established, the patient should be referred to a clinical geneticist as soon as possible.

This patient met the minimal criteria for the diagnosis of the oculodento-osseous syndrome[4]: characteristic facies, microcornea and syndactyly of the fourth and fifth fingers. In addition, he had absence of the middle phalanges of the second through the fifth toes bilaterally, which is considered to be a constant and characteristic feature of the disorder. The condition must have arisen as a fresh gene mutation in this patient, since it is inherited as an autosomal dominant trait, and no other member of the immediate family was affected. This assumption appears to be substantiated by the finding of Jones, *et al.*,[9] that new gene mutations for this condition occur more often at older paternal age, as in this patient. ◂

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In the Community Hospital

Synergistic Armamentarium For Schizophrenia Treatment

By William Bauer, M.D./Milwaukee, Wisconsin

Remission can now be achieved in many cases of schizophrenia if the patient is treated early in the course of the illness. Successful treatment usually utilizes various combinations of the many modalities available for this purpose.

The acutely psychotic patient must be treated quickly, and with a multiplicity of efforts directed simultaneously at many facets of the illness in order to achieve and sustain a good remission. Time limits arbitrarily placed on acutely ill patients may cause premature discharge with subsequent relapse and increased risk of chronicity in the patient. The time requirements of each patient are uniquely definitive. Artifacts of this nature should not be introduced into the already complicated treatment process when dealing with the acutely ill psychotic.

Some of the therapeutic "tools" which must work *simultaneously* for prompt remission are as follows.

First and foremost, there must be a no-time-limit understanding of trust between patient and therapist. The patient must be allowed to feel that the facility and therapist will be available as long as necessary, but at the same time, the therapist and the remaining healthy portion of the patient's ego must be working together to hasten the day that reintegration might occur, reality accepted and self-confidence restored.

Neuroleptic titration must be instituted immediately. The term implies the careful administration of various types of psychoactive chemicals concomitantly, in order to improve disorganized thought patterns and abnormal behavior. It implies the careful selection and application of the appropriate drug for the specific situation at hand. It also connotates a skill acquired by years of clinical experience with the use of these drugs for this particular purpose, in contrast to the routine prescribing of "tranquilizers."[1-3]

The environment must be secure for controlled regression, when and if this need should occur. It is felt that most psychotics have never experienced the security necessary for proper emotional development. Therefore, they may need to regress to the point where security can be experienced on an emotional level before reintegration can begin. Any testing behavior should be met with kind but firm control. The psychotic is testing limits and needs to know that the facility is available to serve as an auxillary ego. At times the patient may not be able to feel this emotional security until maximum limitation has been achieved through such techniques as applied wrist, arm, and/or waist restraints. One-on-one nursing care may also be carefully utilized when possible. The entire staff must be ready and willing to respond quickly to patient needs. Many patients have expressed, in retrospect, that the point of realization that people did care occurred when they were protected in such a manner. For the psychotic person, this type of regression may be caused by the overwhelmed or "sick" ego. The quiet room is less effective for this purpose because of its isolation, which, in itself, can be a psychotogenic factor at times.

It is important that the patient establish emotional contact with

other human beings. Hopefully this would be with the "primary therapist" or the person who is prepared to follow through with treatment in the months following discharge. Since this is seldom one person's responsibility, it is acceptable for the patient to experience the entire facility as a "place" where he is understood and accepted.

The key to successful treatment of the psychotic individual lies in the coordinated efforts of the staff to attempt to understand the patient from his or her point of view. It is important that the individual feel accepted and unique.[2]

Daily group sessions, usually composed of eight to twelve patients per group, are important in order for the person to have a "corrective family emotional experience." Learning the give and take of the in-patient "family," accepting different opinions as opinions rather than attacks or criticism and working through all sorts of transferences with "siblings" and surrogate parents (therapists) are important aspects of this phenomenon that they probably never experienced with their own families. It is important to learn, for example, on an emotional level, that anger and aggression are not synonomous. To learn that one might feel anger without losing control physically affords a tremendous enhancement to self-esteem and self-confidence. These experiences transcend intellectual awareness and affect change, broadening the awareness of unconscious strivings, not only in terms of origin, but also in terms of development and applicability to contemporary relationships.

The therapeutic milieu must contain openly communicative personnel. This should be a daily—even an hourly—occurrence. Conflicts between staff members must be quickly resolved by open and honest dialogue.

Formal staffings at least once a week are supplemental, and should include all ancillary personnel from referral and placement agencies in addition to anyone relating to the patient in the treatment process.

Open liaison between family and staff as well as family and patient must be ongoing, involving both active therapeutic efforts and daily communications to allay anxiety and guilt feelings. Supportive and instructive group involvement with the family of the psychotic individual is a necessary dimension of the total therapeutic community. For these reasons, the treatment process is most effective when community based.

Occupational and recreational therapy used to help disclose unconsciously-determined behavior are often "key tools" in the armamentarium. These projects and activities must be discussed and utilized in the total procedure, *i.e.,* examined and discussed by the entire "corrective family" and peer group.[4]

And last, but not least, EST also may be employed any time therapy has reached a nonproductive plateau, especially when mood variations are a pronounced factor in the clinical picture.[2,5]

For example, schizoaffective patients may be deeply depressed, retarded, and suicidal. At the same time they may express absurd delusions of persecution, complain of being controlled by outside forces and have a distinct schizophrenic thought disorder. Conversely, patients with similar schizophrenic symptoms may be euphoric, playful, distractible and overactive. In the diagnosis of these cases, the schizophrenic symptomatology takes precedence over affective symptoms,[6] but both components must be recognized and included in the treatment plan.

All of these treatment modalities must be effective and convergent to such an extent as to act synergistically to produce a nonfortuitous remission as demonstrated in the following dyadic case report.

Clinical Case History

An 18-year-old white female coed freshman was brought to the hospital at 5:00 a.m. the day of admission by police, who had found her wandering the streets screaming. She described herself as a "loner" and denied any previous psychiatric illness.

The patient's father was said to be ambiguous with regard to his specific work. She felt that he had a "terrible temper" and was "very emotional." She described him as being a tall, heavy man who was not overly affectionate. The patient's mother, five years younger than her husband, was described as "very practical." She was employed as a secretary. Her mother was said to be "shorter than her father." The patient also said that her mother "forgave, but never forgot." She had often expressed forgiveness for failure but had always "thrown it in her face later on." Her father also never expressed his anger immediately, but demonstrated it at a later time for some unrelated reason. There was one younger brother, aged 13, and a younger sister, 15.

The patient had only one friend when she was a child, and lost that friend in the sixth grade because of "diversity of interests." When she was in the seventh and eighth grades, she wore only black clothing, including black tights, and she wore a black hat to school every day. She was "rejected" by her peers because of her unusual dress. She never had any desire to participate in school activities, although she went to several dances and ball games, but did not enjoy them. She spent most of her time reading, and following solitary pursuits.

The patient indicated that her parents also had no friends, and that her mother's only acquaintance was a lady with whom she occasionally had coffee. The parents never entertained in their home, nor did they go out. She felt at one time that she wanted to be a "saint," meaning that she wanted to be perfect, but, in her freshman year in high school, realized that being a saint would be impossible. The patient had no religious upbringing since her father professed to be an atheist and her mother did not belong to any particular church.

The patient ran away from home for a week during the summer of her sixteenth year; the following spring, she ran away again. When she returned from these trips, she was greeted by her parents with simply a "Hi." She says that both of them expressed their anger later, in a belated way, because of something else she had done. On this particu-

lar occasion, it was because she had stayed out beyond her curfew time. She said belated expression of anger by her parents "did not confuse her anymore."

The patient was studying to be a teacher at the university because her parents wanted her to do this. She found it expedient since it would give her an opportunity to do a great deal of reading.

In summary, she described her father as a very demanding, angry, person with expectations that she was unable to meet. She stated that her family "was not really a family," and conveyed the impression that there was a definite absence of warmth in the family circle. In addition, there was an absence of extrafamilial relationships.

A psychologist interviewed the patient and found her to be quite distant in manner. She was administered the Rorschach, the TAT, as well as the MMPI tests. Conclusions reached were that the patient was above average in intelligence, and that the relevance and orderliness of her cognitive processes were subject to great variability. At times, her thinking was goal-directed, organized, and appropriate; but at many other times, her thinking was extremely loose, confused, and pervaded by destructive, florid imagery.

It was felt that the young student was at the vertex of a very excitable, destructive, malevolent, emotional period, induced by a harsh superego. Her feelings toward herself were characterized by highly-charged self-contempt, though she took some pride in her intellectual gifts. Her isolation from people was felt to be extreme and probably of long duration. She had no interpersonal relationships. She seemed to view her father as an evil power, and her mother as a demanding devourer whom she held in extreme contempt.

The Land of Ascendora

"Ascendora is a strange and fascinating land. The hour is midnight! Lightning flashes across the sky to illuminate a tortured landscape. Tree branches writhe ceaselessly to escape their captuous trunks. There is an aura of death! Fear! Simultaneously, interwoven in this matrix of despair, there are symbols of hope and poignant beauty: Butterflies escaping from their cages, intricate syncitia of Zen, the serpent of Eden, and Paradise Lost! This land is a secret place."

It was known to and could only be visited by one little girl, our patient, who had created it in fantasy as a child as a place of refuge from reality. It began as only a tempting thought, but gradually it became more profusely elaborated, eventually seducing its creator into its own mystical culture and traditions. Real (reality based or oriented) emotions were blurred and became unidentifiable, at times completely absent, as the excursions to Ascendora became more frequent and the stays more prolonged. She learned to speak the language and conversed in it exclusively while visiting the serpentine menagerie of which she constantly fantasized. By the time she went to the university, she spoke Ascendorese more fluently than her native tongue. At times, she spoke this language of metaphor and symbolism to her friends. Her strange language was a ticket to the fringe subculture of the campus where it was considered "cool."

One day, the little girl, who suddenly became eighteen, could not return from Ascendora, not because she lacked the ability, but because she lacked the motivation to face the reality of her life. Beautiful, exotic, awesome Ascendora! It was a land of emotional despair. Real feelings were no longer experienced (all of her energies having been channeled into the fantasy of escape). She screamed to see if she were alive. The police brought her to the hospital. She was placed in the psychiatric ward where she remained hurtfully aloof. She seemed very sad and appeared lost in phantasmagoria. She was listening for those words spoken in Ascendorese; words which taunted her unceasingly. The chanted, "Thou shalt dwell in the land of Ascendora forever." The foreboding verdict was final, "irrevocable, and unending—eternal. Infinite."

Days passed; she refused to participate and remained poignantly autistic. She was called schizophrenic. She seemed unreachable in the dream of bittersweet, the land of timeless dichotomies, condensations and ambiguities.

Recovery

Finally, one day, she began to sketch. She worked on the drawing furtively and mistrustfully at first, and later with more enthusiasm. She would not discuss the drawing with anyone and was apprehensive when anyone dared to look. She hid it quickly when the drawing period was over. As time passed, the young girl appeared more deeply depressed. She became upset at the mere mention of her drawing. She was said to be experiencing an illness called schizophrenia, schizoaffective type. In spite of medication and attempts to involve her in reality-oriented dialogue, the depression and autistic withdrawal deepened. Family sessions were planned and executed. Nothing changed. The feeling of hopelessness seemed more firmly entrenched. She refused to discuss the drawing.

At this point, the patient received six electroshock treatments. The intensity of the depressive component of her illness lessened and she began communicating in therapy sessions. One day, with much support and encouragement, she gained the courage to display her drawing. Consciously she was totally unaware of its meaning. When asked to think about it, she said in essence through a series of sessions:

> The tall, angry man in the center of the picture symbolizes my father. My father possesses a terrible, unpredictable temper. He is holding a clock, which probably represents time, the hold he has always had on me . . . and a snake-woman, my mother, in her contemptuous, dominating, deceptive role. The head extending from the side of the angry father figure is myself. I am wearing the Buddist circle of being, symbolizing eternal conflict. The cage containing the skull on the left of the picture symbolizes my death; the butterfly, freedom from death . . . a freedom unobtainable! Finally, the man is emanating lightning, showing his terrible anger.

During the next family session, she explained the meaning of the

drawing to them. She felt greatly relieved and expressed a feeling of closeness with her parents which she had never before experienced.

Without realizing it, the young lady had drawn a picture of the land of Ascendora! After many discussions, the drawing (and the symbolism of a box which she was also making) was fully verbalized and brought into awareness. Suddenly, one day in a moment of introspection, she proclaimed, "I don't want to live there anymore." In the days following, she said on occasion, "Perhaps I may visit there on occasion to calm down, but never will I be an Ascendoran again."

It was not long after the exploration of Ascendora that the patient was discharged. Before she left, she attempted to destroy the box she had made, a Pandora's box from which her fantasy had ascended (hence the neologism "Ascenddora"). The box was later restored by members of the staff.

The patient has subsequently reentered the university, maintains her appointments regularly and looks forward to a future in the field of creative writing.

Summary

This vignette illustrates the synergistic utilization of an eclectic armamentarium of intervening modalities and milieu forces available to the psychiatrist in the hospital-based, community-oriented approach to the treatment of the acute schizophrenic episode. With this type of patient, it should seldom be considered whether a dynamic *or* a somatic (EST, drugs, etc.) regimen is most effective. Rather, it should be that *all* factors working simultaneously as outlined in this paper produce a sustained remission of the psychosis. ◀

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Seeking the Colon Polyp

By Rudolph W. Roesel, M.D., and Harold J. Rothenberg, M.D./Chicago

Early diagnosis of colon cancer requires the identification of all premalignant colon conditions. The adenoma, in all its forms, represents the majority of premalignant lesions.[1]

Hereditary traits, such as familial polyposis, Gardner's syndrome or Turcot syndrome, all relate to the adenoma. Heredity may challenge geneticists with "thought models" for future gene modification. These lesions represent only 3%-5% of colon polyps.[2]

Colon cancer is second in frequency of all visceral cancers in the United States for both males and females. In 1984, 136,000 new cases were reported. This figure had increased from 92,000 cases in 1973, representing a major health concern. Annual mortality increased from 42,000 to 56,000 during the same interval.

In 1983, Illinois reportedly had 3,187 colon cancer cases and 1,358 rectum cancer cases from 114 participating hospitals.

The figures in Table 1 compare the different stages of colon and rectum tumors in Illinois.

By definition, *in situ* and local disease represent Dukes' A and B lesions. Regional spread refers to Dukes' C lesions.

At this writing Dukes' A and B lesions have a five-year survival rate of 75% and this rate is higher for Dukes' A lesions alone. The five-year survival rate for regional disease or Dukes' C lesions is less than 50% at best, which reflects the significance of lymph node invasion. (Table 2)

Table 1
Stages of Colon and Rectum Tumors in Illinois

	In Situ	Local	Regional	Distant	Unknown
Colon	132	1020	1345	625	65
Rectum	75	298	450	255	80
TOTAL	207	1318	1795	880	145

Table 2
Five Year Survival Time for Colon Cancer
(According to Dukes' Classification)

Stage	Survival Rate
A and B1	85%
B2	55%
C1	40%
C2	13% (Lymph nodes positive along vascular pedicle)

New Modalities

Better survival rates depend mainly on early recognition of the neoplasm and subsequent early treatment. In the past, most scientific efforts have been directed toward the treatment of advanced cancer. Treatment modalities are changing, however, as in breast cancer, with the identification of the earlier breast lesion. Similarly, in colon cancer, one could improve survival time by the early treatment of the small lesion of the colon.[3]

What efforts have been made in this direction? Colonoscopy and

flexible sigmoidoscopy are now used more frequently, resulting in more polyps being found and removed. In addition, follow-up care of high risk patients has been intensified. There is evidence that 10% of all polyps may have malignant potential.

The following figures demonstrate the frequency of cancer and polyps at Augustana Hospital and Ravenswood Hospital, Chicago, from 1982 to 1985; Augustana, 59 cases of cancer, 82 cases of polyps, nine cases of polyp cancer; Ravenswood, 110 cases of cancer, 201 polyps and six cases of polyp cancer.

While these figures appear statistically insignificant, they nevertheless reflect an ever growing tendency to seek the polyp. At this time it would seem too early to expect any change in colon cancer mortality. Previous studies in Minnesota have shown that after the use of rigid proctosigmoidoscopy in a controlled population group, the expected cancer rate was reduced.[3]

Another effort to aid early cancer diagnosis is the chemical search for blood in the stool.[4] However, these tests are not specific for cancer since small adenomas do not bleed and larger adenomatous polyps may bleed only at intervals. The hemoccult test, if positive, can be a useful tool in the diagnosis of colon lesions when followed by endoscopy.[5]

Introduction of mass screening with the 35cm scope is a realistic step to take in the future. Early detection of the premalignant lesion prolongs survival time and helps discover more Dukes' A and B lesions.[6]

At this time the rigid proctoscope appears as outmoded as the wooden stethoscope. Use of the rigid proctoscope should be abandoned and replaced by the newer flexible instrument, which can cannulize the entire length of the sigmoid. Obviously, the transverse and ascending colon are thereby not covered and require the use of the full length colonoscope.[7-9]

Evolution of flexible endoscopy is a gradual process. There should be synchronous educational efforts, similar to those employed during the introduction of mammography. Logistics dictate that 35cm endoscopy be carried out by interested primary physicians in office centers as a "primary" procedure at a cost reasonable to patient and insurance carriers.[10]

Financial Implications

According to recent Medicare data, approximately 190,000 colonoscopies were performed in 1982 in the United States. The estimate for 1983 is 208,000 procedures at a cost of 92 million dollars.[7]

The cost of discovering a curable cancer has been estimated at $70,000 in the past. At the Strang Clinic in New York, 26,000 relatively asymptomatic persons underwent 47,091 proctoscopic examinations. From this group, 58 cancers were found, of which 81% were localized tumors.[1]

High medical expenses are justified if a reduction of the incidence of advanced colon cancer can be achieved. Monetary considerations alone should not be decisive factors to limits of medical progress. Lastly, the public's interest must be served. The early removal of the colorectal polyp will decrease the death rate of colon cancer.

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Of Nutritional Status and Disease Outcome

Immunocompetence Assessment

BY RANJIT KUMAR CHANDRA, M.D./ST. JOHN'S, NEWFOUNDLAND, CANADA

Nutrition is an important component in the mosaic of factors that determine biological outcome. Malnutrition is associated with an increased susceptibility to infection. The duration, severity and incidence of infectious illness is increased in undernourished individuals. Impaired immunocompetence is partly responsible for the enhanced risk of infection and other diseases seen often in malnourished groups. Since host defense responses are impaired early in the progressive development of nutritional deficiency, immunologic assessment has been suggested as a functional index of nutritional status and as a predictor of outcome in various diseases.[1-6]

Lymphoid tissues, particularly the thymus, are atrophied in nutritional deficiency.[7,8] Protein-energy malnutrition results in marked histomorphological derangements in the thymus, including reduction in its size and weight, depletion of lymphocytes, loss of corticomedullary differentiation, and swelling and degeneration of Hassall's corpuscles. Paracortical regions of the lymph node and periarteriolar tissue in the spleen exhibit similar changes. The tissue changes may be the result of impaired cellular proliferation, or of elevated free cortisol concentrations, or both. Concomitant infection produces additional lymphoid atrophy.

Cell-Mediated Immunity

Cell-mediated immunity is consistently impaired in nutritional deficiency.[9-11] This component of host defense depends mainly on thymus-derived T-lymphocytes. T cells are enumerated by counting the number of lymphocytes which form rosettes with sheep red blood cells, or by the use of specific monoclonal antibodies. In malnutrition, lymphoid atrophy and impaired maturation result in a decreased number of rosetting T-lymphocytes in the peripheral blood. About 15% of children with moderate to severe protein-energy malnutrition show lymphopenia. In malnutrition, the number of precursor T cells may be reduced, but, more likely, there is impaired differentiation as a result of decreased thymic hormone activity. There is an increase in the number of "null" cells which bear neither B- nor T-lymphocyte markers. Many of these null cells are immature T-lymphocytes containing large amounts of terminal deoxynucleotidyl transferase.

Delayed cutaneous hypersensitivity reactions are *in vivo* measures of T cell function. Both primary and recall challenge with microbial and chemical substances are decreased in protein-energy malnutrition, and improve after oral or intravenous feeding with appropriate amounts of energy, protein, and other nutrients.[12] Mechanisms underlying the deficit in delayed cutaneous hypersensitivity in malnutrition are not clear. Defects in the afferent limb or antigen recognition and processing, in the number and function of the subpopulation of T-lymphocytes responsible for delayed hypersensitivity, in lymphokines and other chemotactic mediators, and in mobilization of polymorphonuclear leucocytes and macrophages may be present singly or in combination. *In vitro,* blast transformation of lymphocytes in the presence of nonspecific mitogen or an antigen is a semiquantitative assay that reflects one T-lymphocyte function. Lymphocytes from protein-energy malnourished individuals often, but not always, show a reduced response. Many methodological considerations may explain the differences in the results obtained from different studies. These include the amount of mitogen, method of obtaining mononuclear cells, presence of

autologous plasma and duration of cell culture.

Antibody Response

Antibody response is generally normal in malnutrition,[13] except when the stimulating antigen requires the help of T cells. Serum immunoglobulin levels are normal or modestly elevated, particularly in the presence of infection. IgG turnover rate depends upon the existence of concomitant infection; it increases during infectious illness and decreases in the occasional malnourished infant with low IgG levels. Hyperimmunoglobulinemia also may be the result of polyclonal stimulation by parasite antigens and antibodies to food proteins. The level of serum IgE is often elevated; associated parasite infection, thymic dysfunction and reduced T suppressor cell function may contribute to this change.

There is a significant reduction in the amount of secretory IgA present in mucosal surfaces.[14] There is a significantly reduced production of specific IgA antibodies following the administration of measles and poliovirus vaccines. These alterations in secretory antibody response may be the result of reduced synthesis by fewer IgA-bearing cells in submucosal locations, or of reduced production of secretory component due to atrophied mucosal epithelium, or of both. In any event, these alterations may increase the severity of respiratory and gastrointestinal infections, as well as permit systemic spread of bacteria and viruses.

Malnutrition affects neutrophils by slowing chemotactic migration and decreasing intracellular metabolic activity and bactericidal capacity.[15,16] Undernourished individuals show reduced levels of C3, C1, C2 and C5, and occasionally other complement components.[17] Total hemolytic activity is decreased. In one study, split products of C3 were demonstrated by immunoelectrophoresis, particularly in patients with infection.[18] Data are limited on the alternative pathway of complement. Factor B concentration may also be decreased.

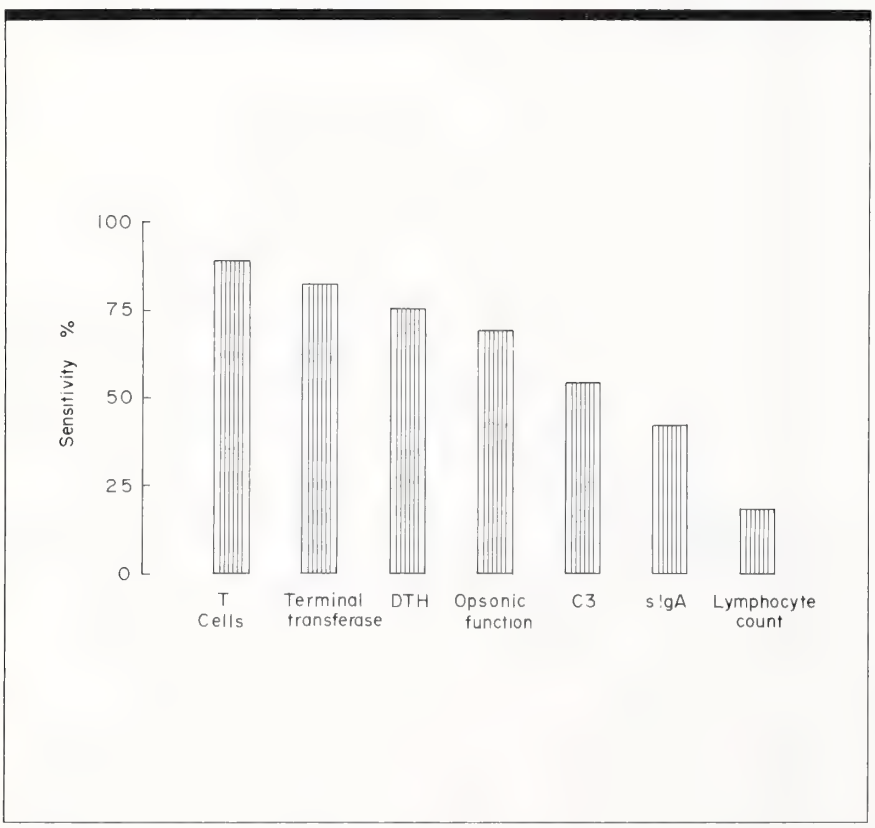


Figure 1
Sensitivity of seven immunologic indices of nutrition among adult surgical patients.

Prediction of Nutrition-Related Morbidity and Mortality

Most of the conventional methods of nutritional assessment measure body size and composition. Few attempt to evaluate function. Thus, the suggestion[1] to use immunologic responses as sensitive functional indices of nutritional state is a distinct departure from the approaches currently in use. The choice of tests would depend upon the study population (inpatients, outpatients, field surveys), and can include,[19] in order of practicality and usefulness, lymphocyte count, delayed hypersensitivity skin tests, complement levels, number of T cells and subsets, terminal transferase activity, and salivary secretory IgA. The methodology, advantages and disadvantages have been discussed elsewhere.[1,2,5]

Evaluation of the usefulness of these tests is far from complete. It is important to examine the ability of these immunologic methods to identify patients with malnutrition and predict the morbidity and mortality. Sensitivity and specificity of testing estimates quantitatively the proportion of patients developing disease who will be diagnosed or missed by using that test, and also the proportion of those patients who will be falsely identified as positive. Positive predictive value provides an estimate of the patients with disease among those who test positive, while the negative predictive value gives the estimate of the patients who will not develop the disease.

The sensitivity of various immunologic indices of nutrition is given in Figure 1. Anergy (absence of skin reactivity to common antigens) is associated with significant increase in sepsis and mortality. The reliability of this procedure for prediction of complications in adult surgical patients is shown in Table 1. It is clear that the sensitivity and specificity values of these tests and their positive and negative value in predicting development of infection

Table 1
Reliability of Preoperative Anergy (Absence of Delayed Cutaneous Hypersensitivity) to Predict Postoperative Malnutrition and Associated Complications*

Outcome	Sensitivity (%)	Specificity (%)	Positive Predictive Value (%)	Negative Predictive Value (%)
Sepsis	61 (50-80)	74 (62-90)	28 (14-39)	92 (84-97)
Mortality	49 (37-60)	74 (60-88)	25 (21-29)	91 (90-92)

**Data are shown as mean (and range) of values obtained from several reported studies, largely based on adults undergoing major surgery for a variety of primary diagnoses.*

and mortality varies considerably from one study to another. This could be due to a number of factors, including the total number of cases in a study, the prevalence of malnutrition in the group studied, selection of the point beyond which a test is considered to be abnormal, the primary diagnosis, and the antigen used.

Conclusion

There are many techniques for assessing the state of an individual's nutrition. These include history of dietary intake, physical examination for signs of deficiency syndromes, anthropometry and biochemical, physical and radioisotope measurement of body composition. In addition, several tests of immunocompetence can be considered as sensitive functional indices of the nutritional state. No one group of tests is satisfactory for obtaining a complete picture of an individual's ability to resist disease. "Tests of immnocompetence are altered early in the development of undernutrition and therefore provide a functional measure of mild deviations from normal nutritional health. They reflect a broad measure of nutrition without being specific for any given nutrient. Assessment of immunocompetence by currently available methods in conjunction with other methods of nutritional assessment can identify individuals who are most in need of appropriate nutritional support, and thus provide crucial prognostic information in terms of risk of disease, duration of hospitalization, and chances of survival. And survival, after all, is what preventive and therapeutic medicine is all about."[5]

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Public Service Award Winners

Commitment, Ability and Character

The first Illinois State Medical Society Public Service Awards were presented at the 1987 annual meeting in April. A physician and a nonphysician award recognized the contributions of winners chosen from nominees across the state. Nomination forms for the next awards, which will be given only as worthy nominees come to the attention of the Society, appear on pages 119 and 120.

The first ISMS public service awards recognized the work of two leaders of Illinois medicine. The physician recipient, Dr. Earl Stockdale, was responsible for establishment of a physician referral network to provide medical care to thousands of medically indigent persons in Rock Island county. The nonphysician recipient, Representative Lee Daniels, minority leader in the Illinois House of Representatives, has championed quality health care legislation throughout his political career, taking a leadership role in passage of medical malpractice reform and working consistently to provide quality care for the handicapped.



Earl M. Stockdale, M.D., the first physician recipient of the ISMS Public Service Award, presented for his work providing medical care to the indigent of Rock Island county.

Mainstream Medicine for the Indigent

"Bringing people into the mainstream of medical care," is how Earl M. Stockdale, M.D., describes the purpose of a rotating referral system for Rock Island county indigent patients. "These folks are people and they deserve compassion," he avows.

A board certified pediatrician in private practice, Dr. Stockdale has donated countless hours of volunteer service to his community and his profession to develop the referral service, and to promote childhood immunization. After nomination by his Rock Island County Medical Society colleagues, his efforts received a formal round of applause by the Illinois State Medical Society House of Delegates. With 13 members of his family looking on, Dr. Stockdale accepted the Society's first Physician Public Service Award at the ISMS annual meeting. The award honors physicians and nonphysicians for yeoman efforts in community service, public education and patient or public health advocacy.

Taking Care of Rock Island's Poor

In the late 1970's, Rock Island County began to see a large influx of southeast Asian refugees. This coincided with the loss of a neighborhood health center, which had closed when federal funding evaporated. These events portended a growing number of public aid and otherwise indigent patients who would have trouble finding a doctor.

That's when Dr. Stockdale first broached the idea of a rotating referral system with his colleagues on the county medical society. Members of the Rock Island County Medical Society Public Health and Policy Committee met to address the problem and to develop a physician referral system to care for these patients. The obstetricians, who faced the first crisis, developed the initial network, followed by physicians in general practice, pediatrics, internal medicine and surgery.

Since then, Dr. Stockdale advises, the system has garnered 98% participation from Rock Island county's, primary care physicians. "And specialists," he adds, "have been very



Dr. Earl M. Stockdale, shown with his family, after accepting the ISMS Public Service Award at the ISMS annual meeting.

good about seeing patients on referral from primary care colleagues." Over the years, more than 10,000 patients have received referrals, for services ranging from obstetrics and primary care to specialized surgical procedures.

Sacrifices and Gains

Just what does the rotating referral system cost physicians? Dr. Stockdale acknowledges that the sacrifice is significant. "We get the amount of reimbursement that public aid pays—somewhere around 40% of our fees. Some patients pay even less. And some pay nothing at all," he explains. The actual charges are worked out between individual doctors and patients. "In short, there is a tremendous amount of free care given."

The gains for Rock Island County's medical profession are perhaps less tangible, but tremendously beneficial. The referral program has boosted the image of physicians with both the public and with public agencies which previously had only scattered options for referring poor people with health care needs. Calls from social service organizations are funneled through the rotating referral program. One side benefit: the average physician's office personnel are no longer beleaguered daily by inquiries from social service workers attempting to place patients.

Dr. Stockdale adds, "Another plus is that people are able to identify with a doctor, thus eliminating recurrent emergency room visits which are totally cost ineffective. The beauty of the system is that it reduces fragmentary care, and encourages preventive medicine and continuing care."

As for abuse by those really able to afford care, Dr. Stockdale and his colleagues have found little evidence. If someone already has a regular doctor, he or she is told to contact that physician. Patients may try to beat the system, if referred to a doctor they don't like, or to one to whom they already owe money. "We usually find out about those few cases," Dr. Stockdale says.

Motivating Colleagues

Only rarely has Dr. Stockdale encountered a physician unwilling to participate in the rotation. Then, he and his participating colleagues exert a little peer pressure. That usually does the trick. "I talk to them and tell them that if they don't do their share the whole thing will crumble, and we can't afford that." Everyone is encouraged to accept their "fair share" of rotation referrals.

Dr. Stockdale is an enthusiastic promoter of this program to other

In Praise of Doctors

Doctors, like lawyers and journalists and professional athletes, have fallen from public favor in recent years. Whereas becoming a doctor was once a glorious goal, it is seen as something considerably less than that by many Americans today. How and why this has happened is beyond the scope of this commentary today, however, for we come not to criticize doctors, but to praise them.

It was reported recently that Rock Island County physicians provided more than $2 million in free care to public aid recipients in the county during the last year, ending May 31. That's something we can all remember next time we hear—or tell—a joke about a doctor and a golf course.

Add to that $2 million in free services to Rock Island County public aid recipients, additional tens of thousands of dollars of free services provided to the unemployed and others who do not qualify for public aid and you begin to see a picture of the modern doctor that is too often overlooked.

Sure, there are doctors who are in the business purely for the money, just as there are some lawyers, some left fielders and, somewhere, even some reporters and editors to whom money is No. 1. Quacks are to be found in any and all vocations. But it is their self-sacrificing, altruistic colleagues to whom we express our sincere appreciation today, on behalf of all those Rock Island County residents who have been helped free of charge.

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physicians. "We've received many calls, from both Illinois and other states. Since we've won the award, another Illinois county has inquired," he says. Advising others to take the plunge, Dr. Stockdale acknowledges that at first it wasn't easy. "None of us had ever done this before. We grew in understanding, and as time went by we learned the hard way."

Rock Island County physicians take pride that the program emanates totally from the private sector—with no state or federal money involved. Only a small United Way grant helps fund the telephone referral hotline. Congratulating not himself, but his colleagues who have so generously given of their time and talents, Dr. Stockdale sums up the effort: "It's a job that's well conceived and well developed. The medical profession is pleased; and the whole community has benefitted."



Representative Lee A. Daniels (R-Elmhurst) winner of the first nonphysician Public Service Award for his work supporting quality health care.

Community leaders have recognized the value of the physicians' contribution, as have members of the media. The editorial reprinted on page 115 from the *Rock Island Argus* evidences a high level of community support. In 1983, Dr. Stockdale was invited to meet with President Reagan at the White House, where he received a certificate of recognition. Three years later, the Rock Island Rotary Club gave the county medical society its Distinguished Community Service Award.

Earl M. Stockdale, M.D., is a member of the Rock Island County Medical Society and the Illinois State Medical Society. He is a grad-

Nominations Open for 1988 Public Service Awards

Do you know a physician, or someone special in your community, who has performed extraordinary public service on health care issues? Do you have a colleague on your hospital medical staff or in your practice who fits the profile of a public service award winner? Is there a local community leader who deserves special recognition?

If so, don't wait! Submit the nominating form insert found in this month's *IMJ* to your county medical society for review. Criteria for nominees are found below.

The Illinois State Medical Society is again this year receiving nominations to honor an Illinois physician and nonphysician for public service and community outreach efforts. The award is not designed as a popularity contest, but rather an avenue for recognition of real, valued contributions to public education on Illinois health care issues.

Physician nominees must:

- Be an ISMS member;
- Spend at least 50% of time in direct patient care;
- Have been in practice for at least 5 years;
- Participate actively in nonreimbursed public service and community outreach activities on health care issues.

Nonphysician nominees must:

- Provide leadership in communicating health care issues to Illinois patients through news media, community affairs or specific public service projects;
- Promote broad, balanced public education on the patient's role in health maintenance;
- Have been an active advocate on Illinois community health care issues for two years;
- Reside and conduct such activities in Illinois;
- Be principals in public outreach efforts. Consulting and public relations firms ineligible.

Nominations

Component medical societies (including county medical societies and recognized specialty societies) of the Illinois State Medical Society shall be entitled to nominate one candidate in each category annually. Outside nominations will also be considered for the nonphysician award. Nominations must be submitted to the ISMS Council on Public Relations and Membership Services by November 1, 1987, accompanied by a personal nominating letter from the county or specialty society president. Members of the ISMS Board of Trustees, the ISMIS Board of Directors, the ISMIE Board of Governors and the ISMS Council on Public Relations and Membership Services are ineligible. For a complete set of rules or further details, please contact the ISMS Division of Public Relations (312) 782-1654. ◀

uate of Jefferson Medical College in Philadelphia, Pennsylvania, and has practiced pediatric medicine for 31 years.

Anyone desiring more information on the Rock Island county physician referral program may contact the county medical society at (319) 323-1916.

Nonphysician Award Winner Seeks Support Networks for the Handicapped

"A primary goal of government is to assist those people who cannot assist themselves," says Representative Lee A. Daniels (R-Elmhurst) with respect to legislation seeking social supports for handicapped persons. Daniels, who is minority leader in the Illinois House of Representatives, received the ISMS nonphysician Public Service Award for his work supporting quality health care, medical malpractice tort reform and aid for handicapped persons.

In addition to his legislative work, Rep. Daniels serves on the Elmhurst Hospital Parent Board and Children's Memorial Hospital Council. He also works to support the ELIM Christian School in Palos Heights, an adult care facility for the developmentally disabled.

Rep. Daniels described for *IMJ* his most recent efforts to assist the developmentally disabled, sponsoring a series of five bills designed to address "aging-out." That term refers to persons who reach age 22 and are no longer eligible for educational assistance from the state, but need further assistance in order to find employment.

"Where we assist the handicapped in achieving their goals and their maximum abilities, we also assist our society," he explained. "If they become employable and are employed, then they, like the rest of society, pay taxes and help support this government and this service for others."

Daniels, whose daughter suffers from multiple handicaps, has sponsored bills for transition programs designed to help handicapped persons plan for living and working arrangements after they leave educational facilities. The bills would establish a support network to coordinate agencies which assist the handicapped. One proposal would increase funding for residential living centers for handicapped adults, and another would subsidize respite care for the families of disabled adults. A bill to provide funding for specialized equipment, Daniels said, could enable persons who might be homebound to seek and obtain gainful employment.

When asked what role physicians might play in these efforts, Rep. Daniels suggested that doctors become knowledgeable about social services available to the families of disabled patients. "We are trying to create a networking facility that enables handicapped young adults to have a coordinated program so that they can maximize their abilities," Rep. Daniels said. "A lot of people suffer from various handicaps, and although they will never be cured, they can overcome some of the difficulties with specialized training. By spending an extra moment with the parents of a handicapped person after that necessary medical treatment is offered, a physician can be an important component of the handicapped individual's achievement."

Rep. Daniels was a key figure in medical malpractice reforms passed by the Illinois General Assembly, and has continued to work for an equitable legislative approach to tort reform issues.

"My experience in working with the medical society has shown sincere commitment to weeding out physicians who do not meet the standards of the community and to disciplining those who are not conducting themselves within the professional standards," he said. "With that as background, I think that the nature of these lawsuits is so potentially harmful to medical treatment as a whole that society should review them carefully and make sure that we offer reasonable protection to our medical community. That includes the elimination of



Where we assist the handicapped in achieving their goals and their maximum abilities, we also assist our society. If they become employable and are employed, then they, like the rest of society, pay taxes and help support this government and this service for others.

frivolous lawsuits and some reasonable limitation on jury awards which recognizes the rights of patients but at the same time recognizes the rights of the medical community as a whole."

Rep. Daniels reaffirmed his support for an equitable medical malpractice climate. "I'm committed to tort reform," he told *IMJ,* "and I'm committed to continue to work on it." When asked what physicians could do to reinforce the importance of further reform in the minds of their legislators, he stressed communication.

"I think anytime a physician has an opportunity to present his or her case within an appropriate environment, they should do that," he said. "Lawyers, particularly trial lawyers, are constant advocates and they constantly advocate their position whether it is a social setting or a business setting. And I think doctors have to do that too. They have to speak out. And they have to be clear."

Public Service Award Nominees Sought

The ISMS Public Service Awards recognize extraordinary commitment to community service on health care issues. Public Service Awards may be given to physicians or nonphysicians who meet qualifying criteria (see box at 116). The ISMS Council on Public Relations and Membership Services will review nominations submitted by component medical societies prior to November 1, 1987. A personal nominating letter from the county or specialty society president is required, along with the completed form printed on pages 119 and 120 of this issue.

County Medical Societies Coordinate Public Service Activities

A number of county medical societies across the state have programs to care for the medically indigent. These independent initiatives represent a spirit of public service akin to that of the Rock Island County Medical Society project.

In 1984, representatives of medical, governmental and hospital groups from *DuPage County* formed a health planning committee whose first project was to find a way to bring health care to the poor of their community. The DuPage Physicians' Medical Assistance Program (DPMAP) was the product of their deliberations and continues to provide care for the indigent of DuPage County.

Volunteers from the DuPage County Medical Society solicited physician volunteers to provide care for the medically indigent. Their services are coordinated by a nurse, who is supported by state funds and directed through the DuPage County Department of Human Services. DPMAP assigns medically indigent patients to a primary care physician, who receives either an office fee of $5 per visit from non-Medicaid patients or public aid reimbursement from patients enrolled in the Medicaid program.

The DPMAP program referred 625 patients for primary care in 1986 alone. Another 1251 received referrals to alternate health care and/or financial assistance services. The county medical society handles additional referrals for specialty care.

Last year, the DPMAP program received one of two honorable mentions in their category when nominated for a Hometown Award. The Governor's Hometown Award Program recognizes volunteer projects which are of particular benefit to the people of Illinois.

The *Peoria County* Medical Society Physicians' Care Program has provided treatment for more than 8,000 families since its inception in 1983. Volunteer physicians accept referrals and provide treatment at no charge or accept partial payment through Medicaid or township relief.

Nearly all of the Peoria county allergists and pediatricians have joined the program, as well as the majority of the internists, dermatologists, and ophthalmologists. About half of the family practitioners and OBGYNs have also elected to participate.

Three years ago, the program received a C-Flag Presidential Citation recognizing its work for the medically indigent of Peoria County.

The *Will-Grundy County* Medical Society has been working for two years to establish a clinic for medically indigent patients. The work has led to development of a community-based task force, consisting of community leaders from all walks of life. The task force, in turn, has created a private not-for-profit corporation to establish and maintain such a clinic. Once it's up and running, physicians will staff the clinic as volunteers, receiving no remuneration.

Physicians who are particularly active in community service efforts may be appropriate nominees for the ISMS Public Service Award. To recommend someone for an award, members should refer to the information on page 116 and the nomination forms on pages 119 and 120.

OBITUARIES

CORRECTION: We apologize for an inadvertent omission in the obituary of Dr. Mollie Orloff in the July *IMJ*. Dr. Orloff, who died April 23 at the age of 79, was also a member of the Fifty Year Club.

****Balthazar, Eugene R.,** Aurora, died June 14, 1987 at the age of 85. Dr. Balthazar, a 1926 graduate of Loyola University Stritch School of Medicine, Maywood, was the recipient of ISMS' first Humanitarian of the Year Award in 1973. At age 70, he founded the Aurora Free Medical Clinic, which provided free medical service to the poor.

****Banton, Huston J.,** Jacksonville, died June 8, 1987 at the age of 89. Dr. Banton was a 1927 graduate of the University of Illinois College of Medicine, Chicago.

***Burnstine, Marcus D.,** Sterling, died May 21, 1987 at the age of 74. Dr. Burnstine was a 1937 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

***Kopp, James V.,** Peoria, died June 29, 1987 at the age of 47. Dr. Kopp was a 1968 graduate of the University of Illinois College of Medicine, Chicago.

****Langendorf, Richard,** Chicago, died July 8, 1987 at the age of 79. Dr. Langendorf was a 1932 graduate of Deutsche Universitat Medizinische Fakultat, Praha, Czechoslovakia.

****Sered, Harry,** Chicago, died June 9, 1987 at the age of 95. Dr. Sered was a 1917 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

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Impaired Physician Committees

Helping Colleagues Find a Foothold

Emotional illness . . . drug abuse . . . alcoholism . . . all are tragic problems regardless of the identity of their victims. Yet these forms of impairment are even more terrible when their victims are health care professionals with responsibility for the well-being of others.

The American Medical Association's eighth National Conference on the Impaired Professional seeks to help health professionals develop practical programs to rehabilitate impaired colleagues. This is the only national forum for the exchange of ideas on the topic of health professional impairment and well-being.

Hosted by the Illinois State Medical Society and the Chicago Medical Society, the conference is slated for October 8-11, 1987, at the Drake Hotel, Chicago. If you are involved in treating impaired physicians, as a member of a hospital impaired physician committee, or in after-care monitoring and re-entry training, this conference will offer valuable information. Its goal is to bring together a variety of disciplines and organizations concerned with impairment of health professionals.

ISMS Committee on the Impaired Physician Chairman L. Michael Newman, M.D., will present opening remarks. The keynote address will feature Donald Ian Macdonald, M.D., administrator of the Federal Alcohol, Drug Abuse and Mental Health Administration.

Hands-on workshops include:

- ☐ Program Design and Implementation
- ☐ Monitoring, Re-Entry, Relapse
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- ☐ Spouse and Family Problems: A Pilot Comprehensive Program
- ☐ Communicating the Impairment Story

Special seminars will explore prevention and education programs for medical schools, residency programs, and for those in nursing, dental, podiatry, veterinary and pharmacy careers. The program will also showcase effective audio-visual materials on impaired physician programs and treatment.

For registration information, please contact the AMA's Department of Registration Services, 535 N. Dearborn, Chicago, Illinois 60610 or phone (312) 645-4987. More information on the conference or on the Illinois State Medical Society's Impaired Physician Referral and Education Program may be obtained by contacting the ISMS Division of Medical Services at (312) 580-2499.

Join your colleagues for a stimulating discussion on the discovery, treatment and rehabilitation of impaired professionals. Learn some potential solutions for this most serious of problems facing health care professionals today. Attend the AMA's eighth National Impaired Health Professionals Conference. ◀

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Morbidity and mortality rates for myocardial infarction are decreasing in the United States. The dominant factor in the cause of death appears to be left ventricular dysfunction. The reduction of known risk factors through exercise, diet, smoking cessation and counseling is the major focus of a cardiac rehabilitation program. Patient attitude has been a valuable predictor of compliance levels, and widowed patients and as well as those who abuse alcohol, appear to be at increased risk. Smokers showed a three-fold increased risk of repeat myocardial infarction than nonsmokers. The authors concluded that in their study of 157 patients with an initial episode of myocardial infarction, the intangible factors of attitude and adherence to medical regimens were less significant in the incidence of repeat infarcts than the initial myocardial damage and the process of atherosclerosis. (Stegman, M., *et al.: Am J Prev Med* 3:3,147-51, 1987)

The annual hospitalization rate because of childhood poisoning for the years 1979-1983 was 65.1 per 100,000 children up to age 9. In 1979 there were 75 deaths due to ingestion of poisons. Hospitalization was highest for children aged one and two (216.2 per 100,000 and 184.3 per 100,000, respectively). The highest incidence occurred in the Northeast and South, with more cases appearing in white males than females and more in non-whites. (Rodriguez, J., Sattin, R.: *Am J Prev Med* 3:3,164-70, 1987)

Dyslexic patients were compared to normal readers as to foveal and peripheral vision using a single letter to represent the foveal field and strings of letters for the peripheral field. Dyslexic individuals had a wider visual field than normal readers, but had a masking between the letter in the foveal field and the peripheral letters. Because of this occurrence, teaching dyslexic children may require a different strategy for task directed vision. (Geiger, G., Lettvin, J.: *N Engl J Med* 316:20,1229-33, 1987)

Tissue-type plasminogen activator appears to be the most useful thrombolytic agent in ischemic cerebrovascular disease. Early studies indicate that some stroke cases show spontaneous clot lysis. Since tissue-type plasminogen activator is clot selective, intra-arterial or intravenous tests in early selected cases could prove useful. Streptokinase and tissue-type plasminogen activator used in rabbits 1.5 hours to one day after occlusion of the common carotid and right middle cerebral arteries showed gross hemorrhages when infarct had been present for at least 24 hours. Based on this, it would seem rapid therapy would be crucial. (Sloan, M.: *Arch Neurol* 44:7,748-68, 1987)

One hundred twelve patients with rheumatoid arthritis were studied for 20 years. Functional capacity, radiologic measures of joint damage, erythrocyte sedimentation rate, rheumatoid factor, and mortality were assessed. Active therapy consisted of gold, chloroquine, steroids, and, in resistant cases, penicillamine or cytotoxic drugs. Function improved significantly in the early years, but declined significantly in the 10-20 year cases. The mortality rate of patients with rheumatoid arthritis at the end of 20 years was 35%. The authors suggest that medication may modify rheumatoid arthritis for short periods, but does not alter the long term outcome. (Scott, D., *et al.: The Lancet* 8542:1,1108-11, 1987)

Magnetic resonance imaging is an effective technique for imaging cardiac anatomy. There is good contrast between flowing blood and cardiac wall to illustrate the cardiac anatomy in either coronal, sagittal, oblique, or transverse planes. This procedure is not to be used in patients with electrical or metallic implants. Dynamic imaging may permit evaluation of the functional as well as the present morphologic cardiac status. (Nazarian, G., *et al.: Mayo Clin Proc* 62:7,573-83, 1987) ◀

Sixty-Fifth AMA Auxiliary Annual Meeting

By Sherry Betsill (Mrs. Wesley), ISMSA President-Elect

The Drake Hotel in Chicago was the setting for the 65th Annual Meeting of the American Medical Association Auxiliary. Over four hundred auxilians from around the country met June 21-24 to learn, discuss issues and exchange information and ideas. The Illinois Delegation was comprised of nine auxilians from throughout the state.

The four day AMAA meeting provided a wealth of information. Beginning with briefing sessions dealing with health projects, topics discussed included AMA-ERF, fundraising, legislation and membership strategies. All were well planned and very motivational. Auxiliary leaders were inspired to take the information they had learned back to their constituencies in order to promote the medical profession and improve their own communities.

Featured speakers during the meeting included the former Secretary of Defense, Honorable Donald Rumsfeld; syndicated columnist Mark Shields; TV talk show hostess and actress Oprah Winfrey; and AMA President Dr. John J. Coury.

The opening session of the AMAA House of Delegates began with a report by the 1986-1987 president. Mrs. Mylie Durham of Texas' enthusiasm and vibrancy made everyone feel they were an important and needed part of this organization, which represents 80,000 physician spouses nationwide. Dr. John Coury, AMA president, encouraged us all to become involved with adolescent health initiatives and to educate ourselves, as well as our communities, on important health concerns such as AIDS. It was gratifying to learn, as the state auxiliary presidents presented their reports, that many of the health concerns indicated by Dr. Coury were already being addressed by auxiliaries around the country.

As a volunteer organization of over 80,000 members, the Auxiliary is an important voice in health issues, working hand-in-hand with the AMA and the state and county medical societies. The business of the House dealt with bylaws revisions, organizational affairs and health issues. Health-related resolutions adopted at the meeting were: Education on the Hazards of All-Terrain Vehicles; Support for Smoke-Free Health Care Facilities; Participation in the AMA Adolescent Health Initiative; Education on the Importance of Child Water Safety, Education for the Prevention of Elder Abuse; Continuation of Seatbelt Education and Support of Mandatory Legislation; and Promotion of AIDS Education for Youth.

The Auxiliary also presented a check to the American Medical Association Education and Research Foundation (AMA-ERF) for $1,901,350.64. This represented a combined contribution of auxiliaries around the country who, for the preceding year, had held countless fundraising activities for this purpose. Illinois can be proud of its $104,481.79 contribution included in this total amount. Dr. Robert McAfee, president of the AMA-ERF, expressed gratitude and offered his congratulations to Auxiliary for its ongoing support.

Illinois had much to be proud of during this meeting. First, Illinois was presented a Membership Award in recognition of the newly reorganized LaSalle County Medical Society Auxiliary. Second, during a breakfast sponsored by AMPAC, the first annual Belle Chenault Award was presented honoring auxilians for their legislative and political activities. Although the Award was presented to a Texas auxilian, our own Norma Kiessel (Mrs. Alfred) of Macon County was also presented a letter of recognition commending her many legislative accomplishments. The Illinois Auxiliary continues to be a leader in legislative activities and programs, many of which have served as mod-

els for other state auxiliaries.

Last, but certainly not least, Betty Szewczyk (Mrs. Edward), of Belleville, Illinois, was installed as President of the AMA Auxiliary (see accompanying sidebar). It is an honor for all Illinois auxilians and physicians to have one of our own at the helm of this vital organization. In her inaugural address, Betty challenged auxiliary members to become involved in health projects and to recognize their potential. At the conclusion of the meeting the ISMSA held a lovely reception in Betty's honor, attended by over four hundred delegates and friends.

In conclusion, the 1987 AMAA Annual Meeting provided a unique forum for physician spouses from across the country to come together, deliberate on matters of business, learn, and exchange information and ideas. It provided an opportunity to address the unique concerns of the medical profession and the medical family. It provided an opportunity to grow through learning and understanding. In short, it provided auxilians throughout the country with the tools to better promote, enhance and serve the medical profession and our communities . . . working hand-in-hand with our respective medical societies as a team. ◀

Betty Szewczyk of Belleville New AMA Auxiliary President

Betty Szewczyk, Belleville, was installed as president of the American Medical Association Auxiliary on June 24 during its annual meeting at the Drake Hotel in Chicago. During her term of office, Mrs. Szewczyk, who is married to ophthalmologist Edward Szewczyk, M.D., will focus on teenage drug abuse, sexually transmitted diseases, suicide, and premature pregnancy.

"Adolescent health concerns have always been a major focus of Auxiliary activities, but this year we will step up these efforts," said Mrs. Szewczyk. "We want to provide information on where and how teens can obtain help when it's needed, and teach them to make responsible decisions about their health."



Mrs. Betty Szewczyk, newly installed president of the AMA Auxiliary.

The AMA Auxiliary will also continue its efforts in AIDS education, drunk driving, services for the elderly, prenatal and postnatal care, and seatbelt use.

Mrs. Szewczyk is a past president of both the St. Clair County and the Illinois State Medical Society auxiliaries, where her concerns have always focused on programs for families and children. In Belleville, she was president of the Family Counseling Center of Southwestern Illinois, and a charter member of the Belleville City-Wide Committee to Stop Teenage Drug and Alcohol Abuse (now known as Parents in Action). ◀

Medical Assisting and Nursing

Two Different Healthcare Professions

By Lesa B. Hildebrand, Ed.M., CMA-C

Although the education and training of nurses and medical assistants share much common subject matter, they are distinct professions. This month, we highlight some of the differences.

A licensed practical nurse gives nursing care under the supervision of a registered nurse or licensed physician. The current trend for employment opportunities is in long-term care (nursing homes), and home health settings. A person who successfully completes practical nursing training receives a diploma or certificate. The one-year curriculum generally includes such subjects as: medical/surgical aseptic techniques, nutrition, management of major health problems, and maternal/child health nursing. This curriculum prepares students to take the state licensure examination, which is required to practice in Illinois.

A registered nurse provides and supervises care needed by patients because of illness or disability, and also is involved with the maintenance of good health, under the supervision of a physician. Traditionally, a registered nurse has been employed in hospital environments, but may serve in a variety of settings. A registered nurse may be trained in a two-year associate degree program, a three-year diploma program, or a four-year baccalaureate degree program. Students learn nursing theory and practice, and such general educational requirements as humanities and the social and biological sciences. Graduates qualify for the National Council Licensing Examination (NCLEX) for Registered Nurses. All registered nurses must be licensed.

A medical assistant is a professional, multi-skilled person dedicated to assisting in patient care management,[1] under the supervision of a physician. Medical assistants may be employed in physicians' offices, clinics, medical laboratories and hospitals, in clinical or administrative capacities. More medical assistants are employed by practicing physicians than any other type of allied health personnel.[1] Educational programs offered to medical assistants can be one year in length, resulting in a certificate or diploma, or two-years in length, resulting in an associate's degree. Programs accredited by the Committee on Allied Health Education and Accreditation (CAHEA) include: anatomy and physiology; medical terminology; medical law and ethics; psychology; oral and written communications; medical transcription; recordkeeping and insurance billing; management and care of office property; aseptic techniques; preparation, assisting, and follow-up of patient for medical examinations; medical office emergency situations requiring first aid and CPR; pharmaceutical principles and medication administration; basic office diagnostic procedures; and an externship.[2]

Upon successful completion of an accredited program, students may take the national certifying examination for medical assistants. Other pathways for certification exist for those who do not attend a CAHEA-accredited medical assisting program. Four colleges in Illinois offer CAHEA-accredited medical assisting programs. These are the Belleville Area College, Belleville, program director: Rose Hall, RN, CMA-AC; Robert Morse College, Carthage, program director: Judy Marshall, BS, CMA-C; William Rainey Harper College, Palatine, program director: Vera Davis, RN, CMA; and Triton College, River Grove, program director: Lesa B. Hildebrand, EdM, CMA-C.

For further information regarding the Illinois Society and/or Medical Assisting please contact: Cheryl Hutchison, CMA, ISMA president, 53 Lockhaven, Granite City 62040, or the public relations co-chairpersons: Lesa B. Hildebrand, Ed.M., CMA-C, Triton College, 2000 Fifth Avenue, River Grove 60171; or Lucille Perce, CMA-C, 22W 384 Teakwood, Glen Ellyn 60137. ◀

References

1. American Medical Association: Allied Health Education Directory, Fourteenth Edition, Chicago, 1986, pg. 39.
2. "Essentials and Guidelines of an Accredited Educational Program for the Medical Assistant," adopted by the American Association of Medical Assistants and the American Medical Association, 1984.

Summary of Issues and Actions

Due to the unfortunate death of Allan L. Goslin, M.D., and the resignation of Warren D. Tuttle, M.D., two downstate vacancies were created on the ISMS HMSS Governing Council. According to the HMSS Constitution and Bylaws, vacancies on the Governing Council may be filled by the Council until the next business meeting, at which time the vacancies are filled by a vote of the Section. Accordingly, the Governing Council unanimously elected George T. Wilkins, M.D., as treasurer, and Ross Hutchison, M.D., as member-at-large.

AMA HMSS Annual Meeting

Approximately 65 Illinois HMSS representatives attended the AMA HMSS Annual Meeting on June 18-20 at the Palmer House in Chicago. This represented the largest turnout of any state's delegation. In addition, the following members of the Society's Governing Council served on various AMA HMSS committees: Dennis M. Brown, M.D., chairman, Reference Committee B; Lawrence A. Stone, M.D., chairman, and Thomas C. Malvar, M.D., Teller's Committee; and Albino T. Bismonte, M.D., Late Resolution Committee.

During morning caucuses of the Illinois Section, proposed resolutions and pending issues were reviewed and candidates running for the AMA HMSS Governing Council were discussed.

One particular resolution which drew considerable attention and concern at the meeting requested that the AMA House of Delegates instruct its JCAH Commissioners to oppose changes proposed by the American Hospital Association (AHA) to JCAH Medical Staff Standard 2.1. The Standard currently prohibits unilateral amendment of the medical staff bylaws by the hospital board or medical staff. Carol McCarthy, Ph.D., president of the AHA, appeared at the HMSS reference committee hearing to explain the AHA's intent to remove the last sentence of the Standard which states: "Neither body may unilaterally amend the medical staff bylaws." This sentence was added to the Standard in 1986. The AMA House of Delegates adopted the Hospital Medical Staff Section's resolution opposing any change to Medical Staff Standard 2.1.

The next AMA HMSS meeting will be held during the AMA Interim Meeting, December 3-5, 1987 at the Marriott Hotel in Atlanta, Georgia.

Establishment of ISMS HMSS Subcommittees

The Illinois HMSS Governing Council, in an effort to increase input from representatives and improve the Section's review process, established the following five HMSS subcommittees as recommended by Joseph L. Murphy, M.D., chairman:

- *Membership Committee.* This committee was established to recruit HMSS representatives at hospitals without representation, and enhance the participation of the existing representatives in the Section's activities;
- *Programs, Agendas and Issues Committee.* The primary responsibility of this committee will be to develop the ISMS HMSS annual meeting program and agendas for other major ISMS HMSS meetings;
- *Screening Committee on Elections.* This committee will review and recommend national or local candidates for the AMA HMSS Governing Council;
- *Committee on Resolutions.* The charge of this committee is to determine if any ISMS resolutions should be referred to the ISMS HMSS, and ultimately, to the AMA HMSS for consideration and to develop pertinent resolutions for consideration by the ISMS HMSS and its Governing Council; and
- *Constitution and Bylaws Committee.* This committee will review the ISMS HMSS Constitution and Bylaws annually to recommend possible amendments.

Illinois HMSS representatives are encouraged to join any of these subcommittees and may obtain further information by contacting ISMS HMSS at 312/782-1654.

HMSS Eligibility Requirements

All Illinois medical staffs are eligible to have one voting representative on the ISMS HMSS. Representatives must be ISMS members with active clinical privileges, and should be elected by the medical staff. Representatives to the AMA HMSS are automatically members of the ISMS Section unless the medical staff decides otherwise. The ISMS HMSS Governing Council strongly encourages each hospital to elect an HMSS representative. For more information regarding ISMS HMSS activities or membership, please contact the ISMS HMSS. ◀

Team Physician Awards

Five physicians were winners of the 1986-87 ISMS Team Physician Awards: Richard Dominguez, Carol Stream; Roger Hendricks, Herrin; Russell Oyer, Chenoa; James C. Reid, Greenfield; and Howard Sweeney, Evanston.

Winners were selected among physicians who had provided ten years of voluntary service to their local schools treating young athletes and educating coaches, trainers, parents and athletes about the importance of prevention and treatment of injuries. Each was an ISMS member who had worked in sports medicine and had also served their communities in a variety of ways.

The ISMS Team Physician Award was established in 1982 to recognize physicians who dedicate themselves to young athletes of their communities. The ISMS Sports Medicine Committee solicits nominations from all high schools, colleges, and county medical societies throughout the state. Over 50 physicians were nominated for this year's award.



The 1986-87 recipients of the ISMS Team Physician Awards, given to physicians who have dedicated themselves to providing services to the young athletes of their communities. (L-R) Howard Sweeney, M.D., Evanston; Richard Dominguez, M.D., Carol Stream; James C. Reid, M.D., Greenfield; and Roger Hendricks, M.D., Herrin. The fifth award winner, not pictured, is Russell Oyer, M.D., of Chenoa.

Exchange Insights

August 1987

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

Some Personal Thoughts on "PR" (Patient Relations)

by Edward T. Butt, Jr., J.D.

Despite my best intentions, I recently had occasion to deal professionally with the medical profession. While recovering from hernia surgery, I had a chance to reflect on the process I had just been through. It allowed me to personalize the experiences related to me over the years by family, friends, neighbors, and plaintiffs.

What, you may ask, qualifies my personal musings for inclusion under the heading of "loss prevention?" Fifteen years of taking depositions of medical malpractice plaintiffs has convinced me that many malpractice cases are based as much on each patient's subjective feeling of impersonalization as on an untoward result or a belief that the treatment was negligent. Thus, this article is intended to help you think about "PR" from the patient's perspective.

Remember, this is not a typical patient writing. On one hand, my interaction with physicians concerns the worst one percent of a very small percentage of complications. I know too much about what can go wrong and too little about what can go right.

On the other hand, I appreciate much more than the typical patient that medicine is as much art as it is science. Also, I am on a first name basis and socialize with many of my personal physicians. This access allowed me to override the head nurse and call my surgeon at home; something most patients would never think of trying.

This article is in no way meant to be critical of any of the physicians or other medical people with whom I dealt. On the contrary, I respect them even more now than I did before treatment. So for the good of all, and at the risk of offending those people whom I still clearly respect the most, I offer these observations.

1. Patients Appreciate Written Discharge Instructions

The nurse read the discharge instructions to me and made me sign them—the hospital has a good lawyer—but twelve hours later in the middle of the night when the effects of the medication were wearing off, I could not have remembered whether she discussed medication or read me the Gettysburg Address. "Can I eat this?" "What do I do if this happens?" "How high of a temperature should I worry about?" I must have read those instructions more than 20 times.

Every surgeon should have available, as mine did, a preprinted set of postoperative instructions concerning the procedures he or she does frequently, and the surgeon should see that those instructions are given to patients who undergo those procedures.

2. Discharge Instructions Should List Separately Possible Complications and Side Effects

Complications: Even though I have heard scores of surgeons testify that a "moderately elevated" temperature a day or two after surgery is not a cause for concern, I was mildly apprehensive when my temperature rose to 100.1 degrees. My instructions, however, told me to call if my temperature rose above 101 degrees. The fact that I had instructions and that they were specific as to when I should be concerned was reassuring to me, and saved my surgeon from getting a call.

When listing signs of complications, it would be helpful to state why the patient should be looking for them, what the patient should do, and what will happen. For example:

The following are signs which may indicate that a complication has arisen:

1. _____
2. _____ Etc.

If any of these occur, call my office at 555-5555 day or night. Either I, or the physician on call, will ask you for more detailed information and will tell you what, if anything, to do next.

Also, it is not enough to tell a patient, as I heard one nurse say to someone else, "Let us know if there are any signs of infection." Patients do not know what is or is not a sign of infection.

Side Effects: In my view, side effects are those things which might occur but can be safely ignored. Patients should be told about possible side effects because otherwise they will not ignore them. They will worry and fret and try to call you about something that could well be ignored.

I suffered one of these harmless side effects. No one told me that there was a 5-10 percent chance of its happening. As a result, my surgeon's partner was bothered on Saturday night when, after worrying about the situation all day, it got worse at bedtime. From a medical perspective, the problem is trivial; thus, it probably never occurred to any medical person to warn me. From the patient's view, however, the feared loss of one's reproductive organ is anything but trivial. Try to figure out which side effects are likely to concern a patient. Tell the patient about them and tell them not to worry.

3. It Is Not Enough To Say "Call If You Have Any Questions"

You may think, especially because you are a friendly, open person who does not really mind telephone calls in the middle of the night, that you can just ask patients to call if a problem arises. Putting aside the fact that patients do not know enough to know when something should be of concern, you are forgetting three problems with this approach.

One, some patients do not want to bother you unless "it is really important" because they believe you are too busy. What if they are wrong about what is important?

Two, most patients have an inordinate respect/fear of physicians. All the trappings which help make them confident in your abilities also make you seem unapproachable.

Three, and most important, the entire health care delivery system as it exists today is designed to keep patients from talking to you. With every good intention (or maybe unintentionally), your receptionist, your nurse, your answering service, your spouse and the hospital switchboard do everything in their collective power to stop patients from bothering you. Only the most persistent patients can fight their way through this protective barrier.

Is it any wonder that some people do not want to call you with a question unless they think, rightly or wrongly, that it is a matter of life or death. Instead, they worry, get agitated, and maybe become resentful. If something then goes wrong, you are more likely to be blamed.

4. Tell Your Patients Why They Should Do Something

This will come as a great shock to most pediatricians and family physicians: millions of literate, intelligent, well-educated parents do not, as directed, give the entire 10-day prescription of antibiotics to their children. Parents fail to continue medications regardless of what they are told. Clearly their pediatricians have never told them "why."

I urge everyone who prescribes antibiotics to explain *why* it is necessary to take all of the medicine prescribed. Maybe a sign in the waiting room or a note stapled on the prescription would work. In any event, just as children are somewhat more likely to do as they are told if there is a logical explanation given along with the order, so, too, are patients more likely to comply with an order if told the consequence of not doing so.

5. Remember The Patient's Family

Most often close family members wait anxiously, even fearfully, while their loved one undergoes surgery. The surgeon is busy during the operation, and time moves quickly. The family members wait and stare at the clock. For them, time creeps. When the surgery is supposed to start at 7:45 and take one hour, every second past 8:45 is an eternity for these people. Given their frantic state, it is little wonder that a key part of "PR" should include the patient's relatives too.

If the patient dies or becomes incompetent, it is the patient's family who decides whether to sue. Even in the case where the patient recovers well, the family members can affect the patient. Therefore, what the surgeon tells the family is very important to how the patient evaluates the results.

Conclusion

In both my profession and yours, getting good results is important. The subjective feeling of the client or patient, however, can have just as much to do with how the patient or client evaluates the results. "PR" can greatly improve those subjective feelings.

Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

September

Anesthesiology

The Use and Interpretation of Monitoring New Technologies
For: Anesthesiologists. Symposium, September 11-13, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 15.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Cardiology

Contrast Echocardiography Symposium: New Techniques in Profusion Imaging, Contrast Echo and Esophageal Imaging
For: Cardiologists. Symposium, September 17-18, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $100. **Reg. Limit:** 125. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Coronary Angioplasty—Indications/Outcomes (Post/Pre)
For: Physicians. Lecture, September 22, DeKalb. **Sponsor:** Kishwaukee Community Hospital. Rt. 23 and Bethany Road, DeKalb 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour, AAFM Prescribed: 1 hour. **Contact:** K.P. Reddy, M.D. **Phone:** (815) 756-1521 x 3486.

Specialty Review in Cardiovascular Disease
For: Internists, Cardiovascular Specialists. Lecture, September 27-October 1, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** None. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Dermatology

Specialty Review in Dermatology
For: Dermatologists. Lecture, September 14-18, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 39 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Day of Learning
For: Physicians and Residents. Lecture, September 16, Evanston. **Sponsor:** Great Lakes Dermatological Society, 2434 W. Peterson, Chicago, IL 60659. **Fee:** $60. **Reg. Limit:** 100. **Credit:** Category 1: 6 hours. **Contact:** Silas Wallk, M.D. **Phone:** (312) 973-2666.

Emergency Medicine

Written Board Review Course—Preparing for Written Board Exam
For: Emergency Physicians. Seminar, September 10-15, Itasca. **Sponsor:** Illinois Chapter of American College of Emergency Physicians, 1645 Des Plaines Avenue, Suite 16, Des Plaines, IL 60018. **Fee:** $475 members, $425 residents, $525 non-members. **Reg. Limit:** 300. **Credit:** Category 1: 53 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

Endocrinology

Specialty Review in Endocrinology & Metabolism
For: Internists, Endocrinologists. Lecture, September 14-18, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

General Practice

40th Annual Clinical Refresher
For: Interested physicians. Lectures and workshops, September 16-19, Chicago. **Sponsor:** Chicago College of Osteopathic Medicine, 5206 S. University Avenue, Chicago, IL 60615. **Fee:** $250; $275 after September 9. **Reg. Limit:** None. **Credit:** Category 1: 21-27 hours. **Contact:** Marie Kowalsky. **Phone:** (312) 947-4606.

Plastic Surgery

Third Annual Plastic Surgery in Primary Care Conference
For: Physicians, allied health professionals. Conference, September 25, Madison, WI. **Sponsor:** University of Wisconsin, 465A WARF Building, 610 Walnut Street, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 7 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Hospice Pain Management

For: Physicians. Lecture, September 29, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K. P. Reddy, M.D. **Phone:** (815) 756-1521 x 3486.

Oncology

Specialty Review in Medical Oncology
For: Internists, Oncologists. Lecture, September 14-18, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Pediatrics

Drug Abuse in Children
For: Physicians. Lecture, September 1, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K. P. Reddy, M.D. **Phone:** (815) 756-1521 x 3486.

OBGYN

Clinical Symposium on Preterm Birth Prevention—State of the Art. **For:** Physicians. Symposium, September 3, Matteson, IL. **Sponsor:** March of Dimes Birth Defects Foundation, One North Dearborn St., Chicago, IL 60602. **Fee:** $50. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Pamela Ippoliti. **Phone:** (312) 407-4007.

Psychiatry/Family Practice/Internal Medicine

Overweight: Recent Advances in its Management: Update
For: I.M. Physicians, Dieticians, G.I., Nurses. Lecture, Slides, Q&A, September 16, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** $50. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Eating Disorders

For: Physicians and allied health professionals. Conference, September 22-23, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705, and University of Wisconsin Hospital, Eating Disorder Program. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP Prescribed *Credit pending;* University of Wisconsin CEUs and American Dietetic Association: 10 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Radiology

Mammography
For: Physicians. Lecture, September 15, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K. P. Reddy, M.D. **Phone:** (815) 756-1521; x3486.

October

Critical Care Medicine

Sixth Annual Chicago Critical Care Symposium
For: Physicians, Physicians-in-Training, and Nurses. Lectures, panel discussions, October 15-18, Chicago Downtown Marriott Hotel. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** $390 Physicians/$245 Physician-in-Training, Nurses, Health Specialists. **Reg. Limit:** None. **Reg. Deadline:** October 15. **Credit:** Category 1: 24.5 hours; and AAFP Prescribed. **Contact:** Ben Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Ophthalmology

Laser Treatment of Common Fundus Diseases—Why, When & How
For: Ophthalmologists. Workshop, October 9-10, Concourse Hotel, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME, 465A WARF Building, 610 Walnut St., Madison, WI 53705. **Fee:** To Be Announced. **Reg. Limit:** 90 **Credit:** Category 1: 10 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Pediatrics

Seminars in Pediatrics
For: Physicians and other health professionals. Conference, October 23-24, U.W. Hospital, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME, 465A WARF Building, 610 Walnut St., Madison, WI 53705. **Fee:** To Be Announced. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP Prescribed. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, October 23-25, Holiday Inn Mart Plaza, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** 175. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

November

General

Teaching Stress Management and Relaxation Skills
For: Physicians, Nurses, Health Professionals. Workshop, November 9-13, La Crosse, WI. **Sponsor:** University of Wisconsin-La Crosse, Wisconsin Heart Institute, La Crosse, WI. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours. **Contact:** Philip K. Wilson. **Phone:** (608) 785-8686.

Pulmonary Disease

Weekend Refresher in Pulmonary Diseases
For: Primary Care Physicians. Lecture, Case Studies, Q&A, November 13-14, Eagle Ride Inn & Resort, Galena, IL. **Sponsor:** University of Illinois College of Medicine at Chicago, 912 South Wood St., 2 North, Chicago, IL 60612. **Fee:** $180. **Reg. Limit:** 120. **Credit:** Category 1: 10 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-8025.

Primary Care

Diagnosis & Pitfalls of Common Hand Injuries
For: Physicians who treat acute hand trauma. Course, November 21, Chicago. **Sponsor:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, CO 80014. **Fee:** $125/$75. **Reg. Limit:** 250. **Credit:** Category 1: 7 hours. **Contact:** Anne Turner. **Phone:** (303) 755-4588.

Neurology

Clinical Neuroimmunology V
For: Neurologists. Symposium, November 5-8, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—to join an established four member group of general internists in Bloomington-Normal, Illinois. Complete office facilities. Midwestern University community with strong economic base. Contact: Judy Buchanan, Administrative Director, The Health Center, 702 North East Street, Bloomington 61701, (309) 827-5051. (6)

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FLORA:
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LA HARPE:
Rural western Illinois community of 1500 (service area of 5,000) is seeking a Family Physician. Good schools, close to Mississippi River, within 25 miles of university. Small community hospital affiliated with regional medical center. Guarantee plus moving expenses. Contact: Byron Mueller, M.D., 112 Main St., La Harpe 61450, (217) 659-7613; or Richard Miller, Administrator, La Harpe Hospital, B St. & Archer Ave., La Harpe 61450, (217) 659-3011. (6)

OQUAWKA:
General Practitioners/Family Practitioners. Ideal facilities in a rural community in beautiful western Illinois. Excellent income potential and fringe benefits; no capital investment; CME available; hospital affiliation; shared call with second physician; all administrative duties handled by efficient, dedicated staff. Contact: Bayard S. Galbraith, Adm.; The Health Center; P.O. Box 118, Oquawka 61469; (309) 867-2202. EOE (9)

EKG

(continued from page 73)

Answers: 1. C, E 2. D

The twelve lead ECG shows normal sinus rhythm with normal PR, QRS, and Q-T intervals. There are single premature ventricular beats seen in the limb leads and a triplet of ventricular beats or a short run of ventricular tachycardia seen in the precordial leads V_{4-6}. The ST-T waves are depressed in leads 1, V_2-V_6.

The history of abrupt episodes of weakness and complex ventricular ectopy seen on the routine ECG would suggest an arrhythmia as the etiology of the weakness. All of the suggestions in question two could lead to the solution. However, more ventricular arrhythmias will be picked up by the ambulatory ECG because it records the ECG over a longer period of time.

Myocardial toxicity from her chemotherapy was considered, but seemed less likely in the absence of heart failure. The twenty-four hour ambulatory ECG revealed four episodes of ventricular tachycardia averaging 100 beats per episode. Symptomatic weakness occurred with each run of ventricular tachycardia. Lidocaine, mexiletine and tocainide failed to control the ventricular tachycardia; procainamide worsened it. Finally, amiodarone was given, and allowed a return to sinus rhythm. The patient had no further episodes of weakness. However, her alkaline phosphatase was elevated. A liver-spleen scan was obtained which showed multiple small filling defects consistent with metastases from the oat cell carcinoma in the lung. Because of this carcinoma with probable metastases, her prognosis was guarded. ◀

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DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Donald H. Wortmann, M.D., has been named chairperson of the department of pediatrics at the University of Illinois College of Medicine at Rockford. A faculty member at UICM since the college's inception in 1971, Dr. Wortmann will succeed **William Langewisch, M.D.,** who has served as acting chairperson since 1985 . . . **Ronald J. Ciskoski, M.D.,** Skokie, was recently named University of Illinois Alumnus of the Year for Service to the Practice of Medicine. Dr. Ciskoski is chairman of pediatrics at St. Francis Hospital of Evanston . . . **Clair Callan, M.D.,** Libertyville, received the Charlotte Danstrom Women of Achievement Award at the April meeting of the Lake Suburban Chapter of Women in Management. Dr. Callan is director of medical affairs, hospital product division, Abbott Laboratories.

The Illinois Academy of Family Physicians recently installed **Delbert L. Harris, M.D.,** Lebanon, as its 1987-88 president. Also named as officers were **Lee B. Sacks, M.D.,** Glenview, president-elect; **Richard H. Leu, M.D.,** Peoria, speaker and **Don E. Hinderliter, M.D.,** Rochelle, vice speaker. **Charles S. Colodny, M.D.,** Libertyville, will serve as chairman of the IAFP Board this year, and **James J. McCoy, M.D.,** Oak Park, as IAFP treasurer. The Academy is a society of over 2,500 members, with headquarters in Oak Brook . . . **Ramesh C. Tripathi, M.D., Ph.D.,** Chicago, has been selected a recipient of the 1987 Alcon Research Institute Award, given in recognition of outstanding contributions in the field of vision research. . . . **James R. Couch, Jr., M.D., Ph.D.,** professor and chief of the division of neurology at Southern Illinois University School of Medicine, was recently appointed secretary-treasurer of the American Academy of Neurology's executive board.

Richard S. Wilbur, M.D., F.A.C.P.E., executive vice president of the Council of Medical Specialty Societies, Lake Forest, has been named president-elect of the board of regents of the American College of Physician Executives . . . The American College of Physicians honored two Chicago physicians at its recent annual meeting. **Dr. Arthur H. Rubenstein,** chairman of the department of medicine at the University of Chicago, was among 13 physicians honored with mastership. Dr. Rubenstein's award recognized his investigative efforts in diabetes and endogenous insulin secretion . . . **Dr. Arthur G. Jones** received the Richard and Hinda Rosenthal Foundation Award for an approach to healthcare delivery that increases its clinical and economic effectiveness. He is director of the Lawndale Christian Health Center, located in one of Chicago's poorest communities.

Lawrence L. Hirsch, M.D., Northbrook, has been named a commissioner on the Northbrook Park District Board . . . New medical staff officers at Rush-Presbyterian-St. Luke's Medical Center include **James A. Schoenberger, M.D.,** Burr Ridge, president, **Walter W. Whisler, M.D., Ph.D.,** Wilmette, president-elect, **James L. Franklin, M.D.,** Chicago, secretary and **David L. Roseman, M.D.,** Chicago, treasurer.

DuPage Medical Society Foundation Awards Grants

The DuPage Medical Society Foundation has awarded $9,000 in scholarship grants to nine area students. Applicants must be intent on a career in health care, and awards are based on ability, merit and financial need. The Foundation, funded primarily by contributions from members of the DuPage County Medical Society, has awarded more than $100,000 to more than 150 men and women since 1965.

Chicago Medical Society Inducts New Officers

Robert M. Vanecko, M.D., Chicago, was inaugurated president of the Chicago Medical Society at its annual meeting in June. Dr. Vanecko, a board certified thoracic surgeon, serves on the Board of Trustees of the Chicago Medical Society and ISMS, and is a member of the board of governors of the Institute of Medicine of Chicago and the Chicago Heart Association. He is an associate professor of clinical surgery at Northwestern University Medical School and is affiliated with Northwestern Memorial, Cook County, VA Lakeside, and Columbus-Cuneo-Cabrini hospitals in Chicago.

Other CMS officers are: **James H. Andersen, M.D.,** Oak Brook, president-elect; **Arvind K. Goyal, M.D.,** Itasca, secretary; **M. LeRoy Sprang, M.D.,** Skokie, treasurer; **Ulrich F. Danckers, M.D.,** River Forest, Council chairman; and **H. Constance Bonbrest, M.D.,** Chicago, Council vice-chairman.

Beware PRIME Says DOI

The Professional Risk Insurers Management Exclusive Co., Ltd. (PRIME) has been ordered to stop selling medical malpractice insurance in Illinois by the Department of Insurance. The company, headquartered in the British West Indies, has been using a Chicago post

office box number in its direct mail solicitations, but it is not licensed to sell insurance in Illinois. The insurance department has warned physicians in the state to avoid PRIME and an affiliated company—International Bahamian Insurance Co., Ltd. (IBI).

Missing Infant Sought

A white male infant born May 22, 1987, disappeared from his hospital room in Maryland on June 11, 1987. The infant, whose name is Jeremiah Thate, is described as approximately 21 inches long, eight pounds, with blonde hair and blue eyes. His blood type is AB negative and he may have stitch marks at the base of the back resulting from a spinal tap, as well as an IV scar on the right or left hand and evidence of a fractured right clavicle. Any information about an infant meeting this description may be forwarded to Special Agent Joseph Corless at the Federal Bureau of Investigation: (301) 265-8080. ◀

Illinois Members in National Roles

John J. Ring, M.D., Mundelein, **Joseph H. Skom, M.D.,** Winnetka, and **Michael L. Neider, M.D.,** Chicago, have been re-elected to their posts as national leaders within the American Medical Association. And **Howard Chodash,** a student member, has been selected to fill a new position within the AMA Medical Student Section.

Dr. Ring, a former member of the ISMS Board of Trustees and delegation to the AMA, was re-elected vice-chairman of the AMA Board of Trustees. Dr. Ring is currently serving his second three-year term on the AMA Board.

Dr. Skom, an ISMS past president and former member of the ISMS Board of Trustees, was re-named to his third term on the AMA Council on Scientific Affairs.

Dr. Neider, who has served as chairman of both the ISMS Medical Student Section and Resident Physician Section, was re-elected AMA Resident Physician Section Delegate to the AMA House of Delegates.

Mr. Chodash, a medical student at the University of Illinois College of Medicine, Chicago, will serve as the first vice speaker for the AMA Medical Student Section Assembly.

Origins of Fetal Brain Injury

The University of Illinois College of Medicine at Peoria and the Northcentral Perinatal Network will cosponsor a one day program on October 21 titled, "Prenatal and Perinatal Factors Associated with Brain Disorders." Speakers will consider the role of pre-labor events and intrauterine history in newborn brain damage. Registration deadline is October 5. Inquiries may be directed to Dr. Tim Miller at St. Francis Medical Center, 530 NorthEast Glen Oak, Peoria 61637 (309-655-2485).

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WOMEN'S ORIENTED MEDICAL Clinic looking for family practitioner or internist—room to grow. 45 miles west of Chicago. Reply to Women's Health Center, 1240 North Highland Avenue, Suite 17, Aurora, IL 60506.

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ILLINOIS ACADEMY of Family Physicians has available an opportunity service for its members to use. IAFP has detailed information concerning over 150 opportunities of different types throughout the state. To receive complete information, mail your C.V. to IAFP—1200 Harger Road, Suite 722, Oak Brook, IL 60521.

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chee, WA 98801; or call (509) 663-8711, ext. 205.

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FAMILY PRACTITIONER. Marshfield Clinic—Durand Center is seeking a board certified/board eligible family practitioner to join another family practitioner in an established office based practice in western Wisconsin. Rural location with abundant outdoor recreational opportunities. The Durand Center offers the autonomy of a private, primary care practice plus the financial and professional resources of Marshfield Clinic, a 250-physician multi-specialty group. Full hospital privileges at the local hospital in Durand. Excellent salary and fringe benefits. Please send curriculum vitae to: Robert Peterson, Director, Regional Centers, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449. Or you may call collect (715) 387-5498.

ORTHOPEDIC SURGERY—opportunities throughout the Midwest and Colorado. These positions offer both general orthopedic practices, along with subspecialized training. Partnership and group settings. Contact: Jean Malkasian, 250 Regency Ct., Waukesha, WI 53186; (414) 785-6500 (collect).

PRIMARY CARE PHYSICIANS—Arizona based physician recruitment firm has various opportunities for BC/BE internists, FP's, and pediatricians coast-to-coast. For further information, contact Mitch Young at (602) 990-8080; or send C.V. to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252.

GALESVILLE, WISCONSIN—Family practice. Immediate family practice opportunity available in rural community—population 1,300 with service area of about 8,000. Newly remodeled, fully equipped branch office is part of 51-physician multispecialty group with 16 family physicians. Diverse subspecialty backup and on-call coverage provided. 23 miles from 350-bed, full-service hospital in LaCrosse. Clinic offers competitive compensation package, including first year guarantee and excellent benefits. Galesville is nestled amidst the picturesque bluffs of southwestern Wisconsin. Year-round recreational resources nearby. Contact P.S. Shultz, M.D., Medical Director, Skemp-Grandview-LaCrosse Clinic, 815 S. 10th St., LaCrosse, WI 54601. Phone (608) 782-9760.

FP/GP NEEDED for 20,000 population town drawing 100,000. Immediate opening as medical-director. Established center. Call after 5:00 p.m. (217) 342-9693.

UROLOGIST—VA Medical Center, Lincoln, Nebraska. Seeking board certified or board eligible urologist for progressive, affiliated 180-bed medical center. Center is affiliated with University of Nebraska for urology residency progam. Salary and bonus pay commensurate with training and experience. Licensure any state. Must meet English proficiency requirement. Allowable moving expenses payable. Write or call: (402) 489-3801, ext. 229. Chief, Surgical Service, VA Medical Center, 600 S. 70th St., Lincoln, NE 68510. Equal Opportunity Employer.

WANTED: ILLINOIS Licensed physicians to perform life insurance histories and physicals. Also ECG. (312) 763-8744.

PSYCHIATRIST for busy hospital/office private practice. Immediate opening with opportunity for partnership. Northwest Chicago suburbs. Forward C.V. to Box #2072, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DERMATOLOGY—opportunities throughout the Midwest and Pennsylvania. These positions offer both general practice along with subspecialized training. Excellent guarantees. Partnership, group, and solo positions available. Contact: Jean Malkasian, 250 Regency Court, Waukesha, WI 53186, (414) 785-6500 (collect).

GREAT POSITION available for family physician or G.P. (others considered) to enhance a large growing practice. Salary, malpractice, vacations, etc. Regular hours-no weekends. Send C.V. to Dr. Michael Hurst, 3401 16th Street, Moline, IL 61265.

CHICAGO AREA: Looking for emergency medicine physicians to staff moderate volume emergency departments in downtown hospitals. Directorship and full time or part time opportunities available. Fluency in Spanish desired. Competitive rates, flexible scheduling and malpractice insurance. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795, or in Michigan 1-800-632-3496.

AMBULATORY CARE CENTER, independently owned, seeks E.M. or F.P. full or part time. Partnership a possibility. Above average compensation. Reply to: Ronald J. Kuchmek, M.D., Administrator, PrimeMed, 2423 Glenwood, Joliet, IL 60435. (815) 741-9310.

INTERNAL MEDICINE Internist/geriatrician seeking BC/BE primary care internist as partner for expanding private practice. Lovely rural community in central Illinois minutes from major cities and medical schools. Salary/malpractice guaranteed. Apply R. A. Weise, M.D., 1109-C North State St., Monticello, IL 61856; (217) 762-9812.

URGENT CARE PHYSICIAN(S) needed now for full or part-time practice at an after-hours walk-in facility attached to a multispecialty clinic in northwest Illinois. Reply to: Bill Sharelis, M.D.-President, Freeport Clinic, 1036 W. Stephenson, Freeport, IL 61032; or (815) 235-5111.

SEEKING DIRECTOR for industrial medicine clinic and emergency department based in moderate volume hospital. Attractive compensation and malpractice insurance provided. Benefit package available. Contact Emergency Consultants, Inc., 2240 S. Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

THREE FAMILY PRACTITIONERS, 3 IM, 2 ENT, 6 Orthopedic Surgeons, 2 Gen. Surgeons: Needed for excellent positions in Middle-Southern IL & MO, excellent opportunity to practice medicine *with less stress.* Contact Dr. Robertson, Midwest Prof. Marketing, 4324 Dupage, Bridgeton, MO 63044, 314-291-5165.

SITUATIONS WANTED

BOARD CERTIFIED OB/GYN and family practitioner with administrative background seeking full or part-time position. Please write: Tad Kohn, M.D., 5509 W. Montrose, Chicago, IL 60641.

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box #2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DIAGNOSTIC RADIOLOGIST: Board certified, interventional and imaging fellowships, experienced in all modalities, seeks locums short term. Available most weekends, some weeks including weekdays. Reply to Box #2051, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

WANTED PRIVATE GENERAL or internal medicine practice. Chicago or suburbs. Reply to Box #2065, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy at (312) 337-4221.

BOARD CERTIFIED INTERNIST critical care seeks to buy primary care practice or to be partner of near retiring physician. Reply Post Box No. 1716, Marion IN 46952.

GENERAL SURGEON I am board certified, have had recent university training. Excellent references and qualifications. Seeking position. Reply to Box #2074, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED ALLERGIST seeking full or part-time position. University trained in adult and pediatric allergy. Please reply to Box #2075, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE, LEASE OR RENT

NORTHWEST SUBURBS—Medical/office space in attractive modern building near Lutheran General Hospital. (312) 967-1300.

FREE RENT to start—medical suite. Also option to buy the suite. Beautiful office in prestigious modern building. Excellent busy location, three exam rooms, lab, private office, washrooms and parking. Also attached garage. Waukegan, IL; (312)662-1664 or (312) 244-3357.

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FOR SALE: ADR 4000 SL Ultrasound machine; price negotiable, Oak Park. (312) 383-9729.

MORTON GROVE, 6000 west, just west of Edens. Affluent community. Move in condition, elevator building, 3 months free rent with lease. (312) 564-4050.

PRACTICE FOR SALE: 63-year-old, second generation general practice; 1½ hour drive south of Chicago; on ground floor in two story building, for sale or rent. Office 12 rooms 2-3 physicians. Excellent accredited hospital 4 blocks away with all specialties. Reply to Box #2066, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL BUILDING and practice for sale. Chicago northwest side. Grossing $72,000 annually, includes office equipment, supplies, and pharmacy business. Relocating. Spanish speaking doctor will stay to introduce patients. Call (312) 907-2223—24 hours.

AVAILABLE SOLO FAMILY Practice, established. Physician retirement. Office in Belleville, IL, near St. Louis. Six figure gross and population base 45,000. Two progressive hospitals locally. Contact J. J. McCullough, M.D. 110 N. High St., Belleville, IL 62220.

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OFFICE SPACE for rent in Hanover Park. Greenbrook Professional Center, Greenbrook and Lake Sts. Special incentives offered. Call (312) 830-2900.

GROWING GENERAL Medicine practice grossing $150,000+ annually. Central Illinois. Medidentic Practice Sales, 460 S. Northwest Hwy, Park Ridge, IL 60068, (312) 696-0220.

FOR RENT 6210 N. Clark St., 750 sq. ft. high density area with conspicuous absence of medical office. Recently remodeled, C/A, pharmacy next door. Rent $600, includes heat. Call (312) 465-8608.

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WINTHROP HARBOR (Future home of 53 million dollar marina) Picturesque chalet style colonial building on wooded lot. 15 hard surfaced parking sites. Lower level 7-room medical suite 1350 sq. ft. Designed for expansion on first floor. Upstairs modern 3 BR apartment 1550 sq. ft. Air-conditioned. Full basement. Heated garage. (312) 746-2020.

SALE: Serometer 380 (Mallincrodt) for office laboratory. Measures most blood tests. $1750. (original price $3500) Call (312) 623-7590 or (312) 244-0220.

FAMILY PRACTICE for sale. 25 years old. City of 12,000 ten miles from St. Louis, Missouri. No OB. Grossing $360,000.00 yearly. Price- one year net income. Reply to Box #2073, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE—Well established family practice. Complete with building. Grossing over $200,000 annually. Desirable south location. Write Medidentic Practice Sales, 460 S. Northwest Hwy., Park Ridge, IL 60068.

MISCELLANEOUS

DISCOUNT HOLTER SCANNING Services starting at $35.00. Spacelabs holter recorder (cassette) available from $1275.00. Cardionostic holter recorder (cassette) available from $995.00. Smallest and lightest holters update. Fast service (24-48 hrs turn over). Hookup kits starting at $4.95. Special introductory offer of three free tests with any purchase or lease of the recorder. Cardiologist overread available for $15.00. If interested call 1-800-248-0153.

MEDICAL TRANSCRIPTION: Federal disability letters, consultations, progress notes; 24 hour toll-free phone-in dictation service; fast turn-around time; fee per line. Certified Medical Transcriptionists (AAMT), qualified in all specialties. Hagedorn Secretarial Service, Inc., "Specialists in medical transcription"; (312)296-0034.

THINKING OF SELLING your practice? We have cash buyers paying highest prices. Have your practice appraised by professionals. Call or write at no obligation. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

A Class Act



Aesculapius, the Greek god of medicine and healing, was put to death by a thunderbolt hurled by Zeus. He feared that Aesculapius just might cure human illness and disease, making humans immortal like the gods themselves, and thus raise hell on Mt. Olympus.

Ever since then, government has had interest in medical care and has paid close attention to developments in the field. Today medical care reaches into society's pocketbook and takes 12% of the gross national product.

With increasing longevity and the technological revolution the bills are very high. Some people might say this may lead to rationing of medical care and limiting expenditures for the care of the aged. Society's elected lawmakers must address these problems and guide and resolve them to a large extent because of the amount of public money involved.

Many problems are caused by inept and hastily drawn laws. When medical care is affected and skewed by laws passed in reaction to problems, errors may occur. Just review governmental reaction to the plague, leprosy, quarantine diseases, swine flu and AIDS. Some bad laws were and can be made in these fields. When broad medical input was sought from all parts of the medical community, instead of from a few people in positions of power, less damage was done. The swine flu fiasco is history and was a boondoggle. Undoubtedly, others can be expected in the future.

But, there is good news too. The Medical Practice Act of 1987, signed into law by Governor James R. Thompson on May 22, is a class act. It was passed without a dissenting vote by the House and Senate of the state of Illinois. It was written after over two years of careful deliberation with the full input of ISMS working with the Governor's Medical Task Force.

This issue of *IMJ* will detail the elements of this Act. Let's not forget our poll results. Ninety-four percent of us knew little or nothing of the old Act under which we were licensed to practice medicine.

Recall that many noxious amendments were proposed and beat back—especially mandatory Medicare assignment. Part of the cost for this was the failure to realize caps on noneconomic malpractice awards. That was a high price to pay and it makes us aware of the value of our Medical Practice Act. We will, of course, pursue our goal of caps until we get them, for the benefit of our patients' costs and the availability of medical care.

The Code of Hammurabi (2250 B.C.) decreed that physicians be awarded adequate fees. Ten shekels was the fee for lancing an abscess of the eye—but if the doctor caused the patient to lose his life or eye, he had his hand cut off or suffered the loss of an eye.

While we will always be at the risk of being broken by governmental power, we *have* come a long way. But watch out for those thunderbolts. ◀

Edward J. Fesco, M.D.

Edward J. Fesco, M.D.
President

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Scott Berman, M.D., department of radiology, Loyola University Medical Center, Maywood.

This 55-year-old man had this excretory urogram because of an enlarged prostate gland.

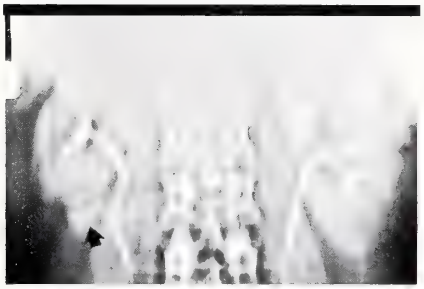


Figure 1
Tomogram from excretory urogram shows a mass (arrow) protruding from flattened lower pole of right kidney.



Figure 2
Oblique view of right kidney shows collection of contrast material (open arrow) in lower pole mass (curved arrows).

Your diagnosis?

1. Renal cell carcinoma
2. Renal angiomyolipoma
3. Duplex kidney, atrophic lower pole
4. Scar from lobar infarct

(continued on page 206)

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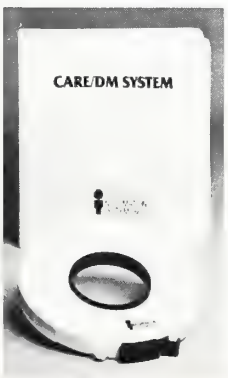
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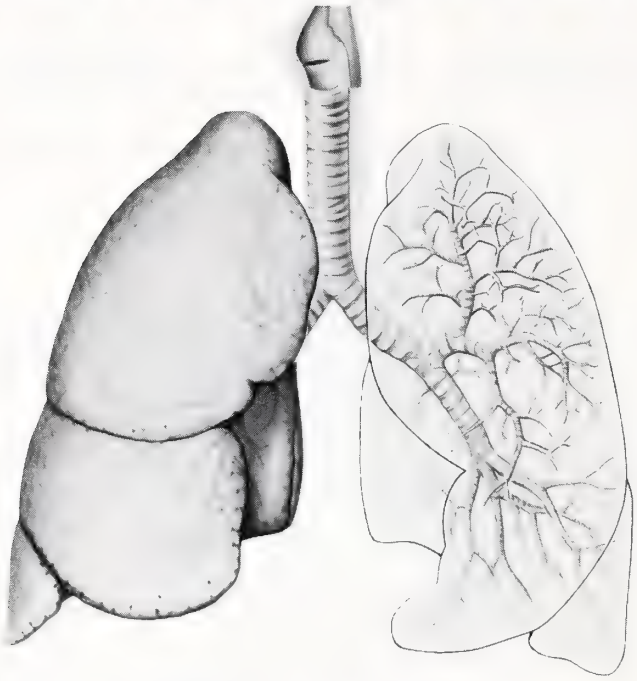
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Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, Streptococcus pneumoniae
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci)

Contraindication:
Known allergy to cephalosporins

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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A Standard of Excellence

In February, 1978, the ISMS Board of Trustees asked J. William Roddick, Jr., M.D., to serve as chairman of the newly established *IMJ* Editorial Board. When he resigned in June, Dr. Roddick had completed nine years' service as arbiter and diplomat. The Society benefitted greatly as a result.

The commitment of personal time was significant. Each manuscript crosses the chairman's desk at least twice. He selects specialty reviewers and evaluates their comments. If a revision is requested, as is often the case with new authors, several versions may be reviewed and revised in turn. While time consuming, commitment to training new writers was a prominent consideration throughout his tenure.

A board certified OBGYN in active clinical practice, Dr. Roddick's commitments were already staggering when he took the helm at *IMJ*. Despite pressing professional demands as professor and chairman of the department of obstetrics and gynecology at the Southern Illinois University School of Medicine at Springfield, he found the time to give each submission thoughtful review.

His nine years with *IMJ* included four as president of the Illinois Obstetric and Gynecologic Society. An associate examiner for the American Board of OBGYN, he is an itinerant residency program site visitor for the Council on Resident Education in Obstetrics and Gynecology. He has long served on the program committee for the annual clinical meeting of the American College of OBGYN—twice as chairman. His is a versatile and energetic mind; only recent appointment as dean of students at SIU forced him to relinquish his commitment to *IMJ*.

The Board of Trustees is in the midst of a study designed to assess our publications program and Dr. David Trachtenbarg of Peoria has graciously agreed to act as interim chairman pending its completion. Any new directions the study might engender will be firmly rooted in the stubborn respect for quality Dr. Roddick established for *IMJ*.

Like so many professional volunteers, Bill Roddick didn't have time to spare. But his is a generous spirit, and a fine, clear mind. We are honored to be in his debt and promise to seek the standard of excellence he has come to represent.

Alfred J. Kiessel, M.D.
Chairman
ISMS Board of Trustees

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The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(conjugated estrogens)

Vaginal Cream

0.625 mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA
Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP). Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria, edema, changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Osteoporosis. Female castration. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart DM, Clark DM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. **2.** Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.

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C I B A

(See Brief Summary of Prescribing Information on the next page.)

*Data on file, CIBA Pharmaceutical Co.

629-7750-A

Transderm-Nitro®
nitroglycerin
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities
The usual dosage is one Transderm-Nitro 5 system every 24 hours Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26) *100 Systems (NDC 0083-2025-30)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26) *100 Systems (NDC 0083-2105-30)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

*Hospital Pack 100's

C85-35 (Rev. 11/85)

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.

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C I B A

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

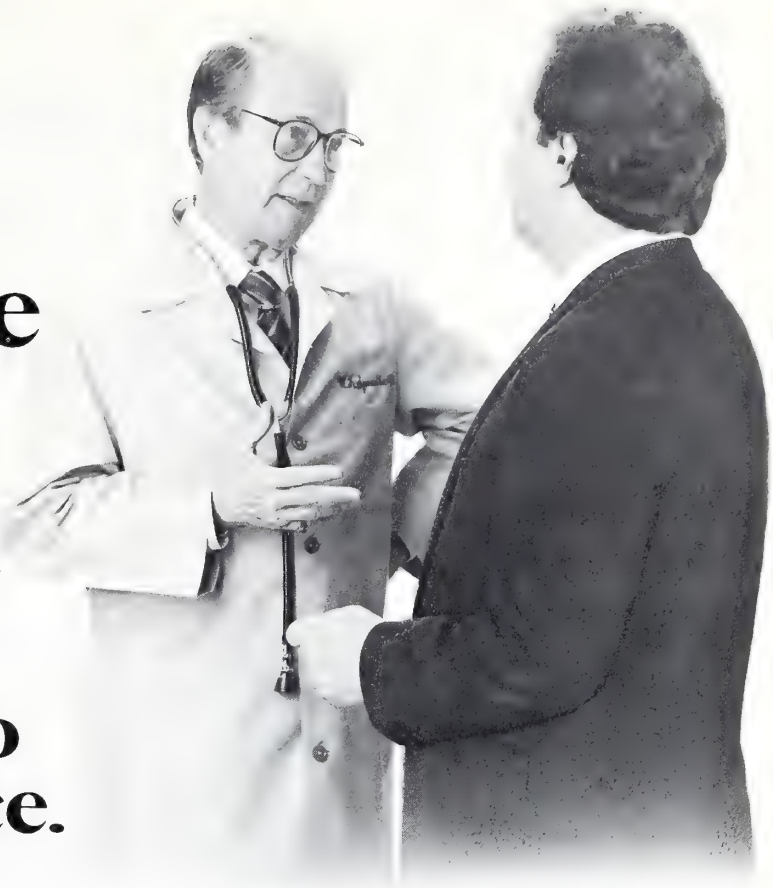
Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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CARAFATE®
(sucralfate)

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:
1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982
3. Brandstaetter G, Kratochvil P: *Am J Med* 79(suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987.

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1594H7

Confronting Pathos With a Smile

By Steven Rubin,
ISMS-MSS Governing Council Member at SIU

We were laughing as we stepped off the elevator and onto the floor that was the hospice. In the family room, a young girl sat giggling in front of the television. Her grandfather was in his room receiving his bath. His condition was deteriorating day by day, but for now he spoke quietly to his wife while the nurse rubbed body lotion on his back. The nurse felt very sad, having known this couple during the many months they had returned for respites. As she turned to leave, she shared a private smile with his wife, which caused the not-so-old man to smile suspiciously at her.

The humor one encounters in a hospice setting is different than in other illness settings. Perhaps its difference is the knowledge that the value of joy in an environment of certain death is immeasurable. To say that laughter serves as a means of relieving tension and stress is not new; to share humor with a dying person or family member can be a new experience for many people. It is a sharing of someone's accepting they are to die, for humor in this instance is a hallmark of maturity.

Physically, the experience of joy provides many benefits: pulse rate is elevated, cheeks flush, respiration improves, and levels of catecholamines are increased. Putative hormones are also released that are thought to relieve pain by action similar to opiates. The forebrain, reticular activating system and limbic system interact to cause, as Charles Darwin stated, "a tickling of the mind." When one realizes there is an element of choice in attitudes and expectations, even the tragedy of the dying child can be faced more easily. The parent who tickles a dying child evokes more than just a primitive laugh reflex. Physical contact gives rise to emotional contact, enabling the child to no longer feel isolated and the "tickler" to better confront reality. Because of these basic inborn reactions, when the time comes, the memory is not only of the child who died, but of the child who lived.

Sharing humor is a dynamic process which reassures someone with a terminal illness that they can still feel happy. When a dying individual can laugh or smile, that person is, in effect, also granting others permission to express joy. It is an effective means of coping for them and their families and deters premature mourning.

THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

A Compact Contract Organizer

The ISMS Office of Contractual Services presents the Informed Physician's "Compact Contract Organizer," designed for quick and easy access to important contract items. It may help you grasp the bare essentials of your contractual rights and obligations when you initially evaluate a contract with your personal attorney. Once you decide to participate in an HMO, PPO or IPA, the "Organizer" signals major items which may require your immediate action and an examination of the detailed provisions of the contract itself. Remove the "Organizer" and use it for all your HMO, PPO or IPA contracts. It can serve as a handy reminder of significant contract provisions.

HMO, PPO or IPA Name _____ **Name of Contract** _____

Contact person _____ **Phone** _____

The Beginning and End

Effective date _____ Contract term _____ (1yr, 2yr, etc.)

Automatic renewal ___ yes ___ no. Termination by prior written notice ___ yes ___ no.

___ days advance notice required. Registered or certified mail required ___ yes ___ no.

Contract continues after "termination" date ___ yes ___ no.

Payment for services provided after termination:

_____ same as during contract_____ fee schedule _____ usual charge _____ other

Contract provides for a patient transfer system upon contract termination: ___ yes ___ no.

Arbitration Clause ___ yes ___ no. Indemnification and hold harmless clause ___ yes ___ no.

Amendment only by written mutual consent ___ yes ___ no _____ other

Amendment notice requirements _____

Effect on Our Practice

Number of our patients covered by the plan _____

Deadline for billing within_____days of date service rendered

Deadline for billing conforms with our usual billing practices ___ yes ___ no

Eligibility verification required ___ yes ___ no

Contact _____ Phone _____ After hours _____

Specific billing forms required ___ yes ___ no

Utilization Review/Quality Assurance

Prior authorization required:

Diagnostic procedures ___ yes ___ no

Referrals within panel ___ yes ___ no Referrals outside panel ___ yes ___ no

Hospital admissions ___ yes ___ no Continued length of stay ___ yes ___ no

Home health ___ yes ___ no Skilled nursing facility ___ yes ___ no

Appeals process for denied authorization ___ yes ___ no

First level of appeal: Contact _____ Phone _____ After hours _____

Second level of appeal: Contact _____ Phone _____ After hours _____

UR and QA performed by _____

Physician UR and QA committee participation required ___ yes ___ no

Liability insurer for UR and QA activities _____

Physician approval required for changes in UR/QA procedures ___ yes ___ no

Reimbursement

Fee for service:

___ % discount ___ fee schedule ___ maximum allowable charge per procedure

Risk sharing withold ___ yes ___ no

Deadline for payment _____ Payment guaranteed by deadline ___ yes ___ no

Interest earned on withhold amount is paid to physician ___ yes ___ no

Right to bill patient for: ___ non-covered service ___ copayment ___ deductible

Capitation:

___ Payment stated in specific dollar amounts

___ Payments stated as percentage of "premium"

___ % withhold in risk sharing pool

___ Participation in incentive pools

Stop Loss Insurance ___ yes ___ no. Threshold amount per patient, per year_____

Deadline for distribution from pools _____

Contract provides for periodic renegotiation of capitation rates ___ yes ___ no

Interest earned on withhold amount paid to physician ___ yes ___ no

Periodic accounting required ___ yes ___ no

Right to bill patient for: ___ non-covered service ___ copayment ___ deductible

Payment mechanism for continuing care rendered after contract termination:

___ usual and customary ___ plan fee schedule ___ other

Deadline for capitation payment _____

Covered Services

Covered services are categorically defined in the contract or an attachment ___ yes ___ no

Plan may unilaterally add services ___ yes ___ no

Plan required to provide notice of added services and discounted benefits ___ yes ___ no

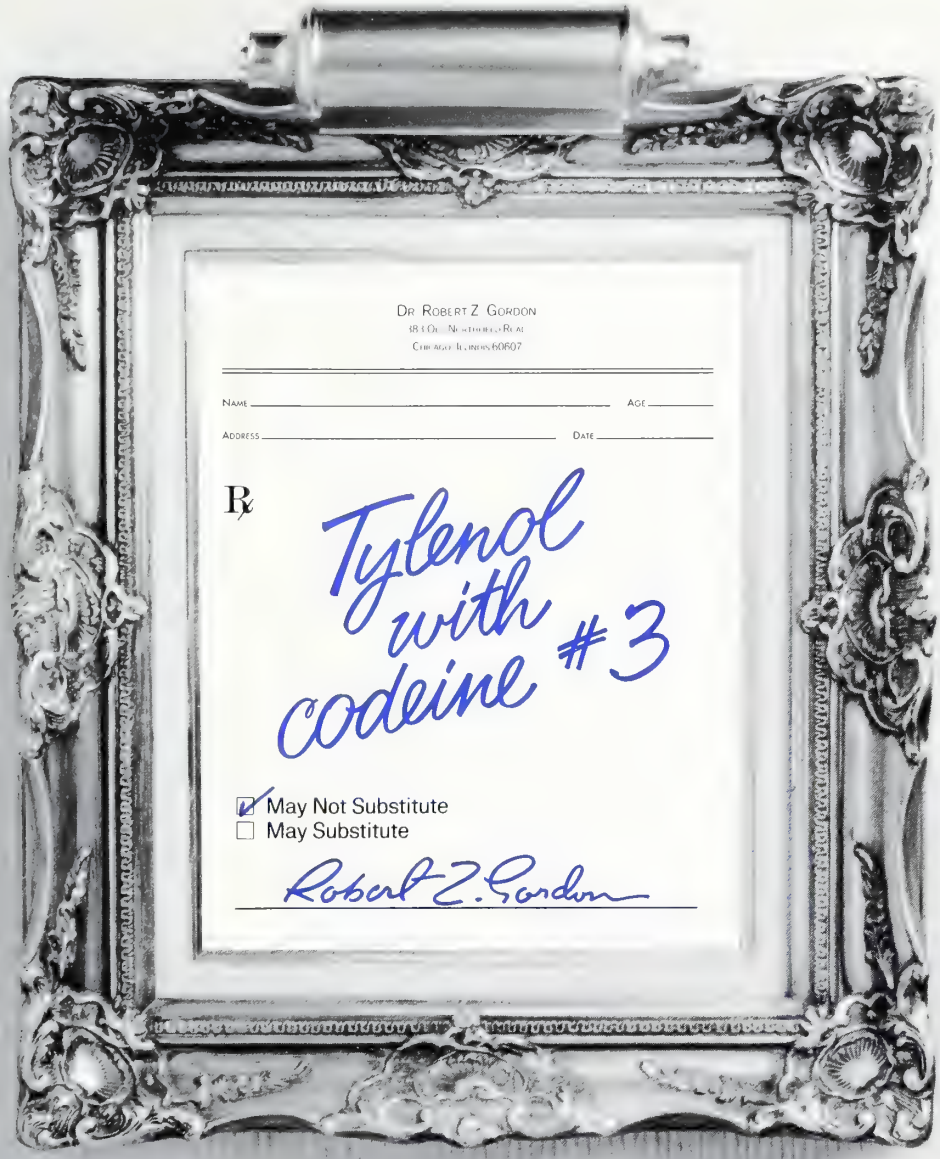
Contract Reviews

ISMS Office of Contractual Services _____

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Professional Liability Insurer_____

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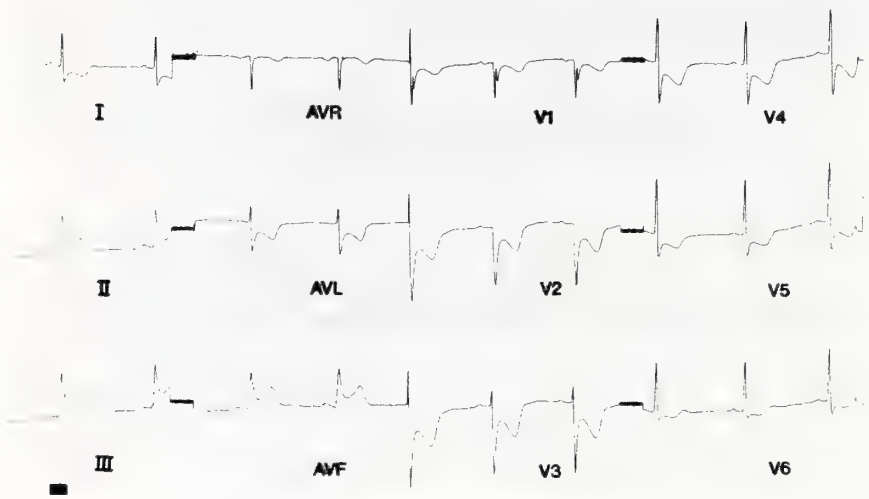
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*Warning: May be habit forming.

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TYCT 6445-A

EKG OF THE MONTH

CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This patient was a fifty-year-old man who had double aorta coronary bypass surgery six years earlier. He developed angina several months after the surgery, but was managed with medication. He continued to smoke cigarettes. One day prior to admission to another hospital, he developed a severe episode of angina which would not respond to nitroglycerin and his other medications. He was transferred for further workup when the pain was present for over twelve hours. The initial ECG at the outside hospital was reportedly normal. This twelve lead ECG was obtained at the time of transfer.

Physical exam showed a blood pressure of 110/70mmHg, pulse was 56 beats per minute. The lungs had bilateral basilar fine crepitant rales. He had a soft ventricular gallop (S_3) on examination of the heart. Since the pain was uncontrolled, an intraaortic balloon pump was placed to allow circulatory support for an emergency coronary angiogram.

Questions:

1. **The twelve lead ECG shows:**
   - A. Atypical complete left bundle branch block.
   - B. A junctional rhythm with aberrant intraventricular conduction.
   - C. ST segment elevation in leads II, III, and AVF.
   - D. ST segment depression in leads I, AVL, V_1 to V_6.
   - E. None of the above.

2. **The following treatment measures might be appropriate.**
   - A. Intravenous thrombolysis with streptokinase.
   - B. Intravenous nitroglycerin for chest pain.
   - C. Emergency coronary angiography.
   - D. Emergency aorta coronary bypass surgery.
   - E. All of the above.

(Continued on page 190)



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als & Objectives

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This year's ISMS All Member Conference is designed to provide answers to some of the questions facing physicians in today's medical environment.

The Malpractice Marketplace

This one-hour session sponsored by the Illinois State Medical Inter-Insurance Exchange Network will overview Illinois' professional liability insurance marketplace. Special emphasis will be placed on new initiatives to provide insurance protection to physicians—specifically the Risk Retention Act and the concept of "channeling."

Managing Risk in the Office and the Hospital

This three-hour session will feature case data compiled by the Illinois State Medical Inter-Insurance Exchange to identify frequent causes of malpractice claims. A general discussion will precede specialty-specific breakout sessions. Preventive measures, such as sound record-keeping practices and good patient communications, will be addressed.

Looking Forward to 1988 Elections

Hard-fought legislative victories have reduced the number of nuisance suits filed against Illinois doctors. But a comprehensive solution to the malpractice problem awaits further legislative reform. Some legal limit—or "cap"—on damage awards for noneconomic factors is essential. But legislation for caps will not pass in 1989 unless favorably disposed legislators are elected in 1988. During a special one-hour session, physicians will gain a perspective of important House and Senate races along with a practical "short course" on how to help elect sympathetic candidates to the General Assembly.

The Malpractice Trial

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Registration Information

The registration fee for the All Member Conference is $50 for ISMS and ISMS Auxiliary members. Nonmember fees are $100. All fees are waived for residents and students.

Registration materials will be mailed to all ISMS members in a few weeks. Further information is available through the ISMS offices: 312/782-1654 or 1/800/782-ISMS.

Managing Change

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Case Report and Literature Review

Carcinoma Arising in an Ileostomy

By Donald S. Ross, M.D., Robert Bussing, M.D., and John Dietrich, M.D./Springfield

Carcinoma arising in an ileostomy is a rare occurrence. A case is presented in which a carcinoma developed 32 years after proctocolectomy for familial polyposis. The literature, consisting of five previously-reported cases in patients with ulcerative colitis, is reviewed. Treatment consists of resection of the stoma and distal ileum, and translocation of the ileostomy.

Permanent ileostomies are most commonly created following proctocolectomy for chronic ulcerative colitis or familial polyposis and its variants. Ileostomies are generally well-tolerated by patients, but are prone to complications, usually mechanical. Adenocarcinoma arising in an ileostomy is extremely rare. Only five cases have been reported in the English language literature.[1-5] The etiology of this lesion is not known, although the five reported cases have been in patients suffering from ulcerative colitis. A case of adenocarcinoma arising in the ileostomy of a patient following proctocolectomy for familial polyposis is presented with a review of the literature.

Case Report

A 56-year-old white female, 32 years status post proctocolectomy for familial polyposis, was admitted because of an "exuberant growth of tissue" around her ileostomy. The patient stated that in the past she had had problems with "granulation tissue" which were treated with topical silver nitrate. Over the past year she had been unable to control the "granulation tissue" and could no longer cover the ileostomy with an appliance. She experienced a 10-15 pound weight loss, decreased appetite and chronic exhaustion. She did not smoke or drink. Other than the original proctocolectomy, the patient had been hospitalized only for childbirths and an episode of acute pancreatitis two years prior to this admission. Her family history was remarkable in that her oldest daughter had died five days prior to this admission of metastatic colon cancer at the age of 33. A second daughter, age 28 is status post proctocolectomy for familial polyposis. The youngest daughter, age 23, has been followed closely and has shown no evidence of colonic polyps.

Physical examination revealed a middle-aged white female who looked older than her stated age. Blood pressure was 84/62, pulse, 125, temperature 98.6°F, respirations 24. Mucus membranes were dry. Chest was clear to auscultation and breasts were without palpable masses. Abdominal exam revealed a 12 × 12cm raised mass involving the ileostomy. The skin immediately around the mass was red and excoriated. Admission laboratory data: white blood count was 11,500, 12 bands, 70 segs, 5 eos, hemoglobin 13.2, hematocrit 43, platelet count 315,000. Urinalysis: Ph5.5, specific gravity 1.018 with many white blood cells and bacteria. Chem 6: sodium 127, potassium 5.9, chloride 9, CO_2 26, BUN 37, glucose 114, alk phos 387, LDH 134, SGOT 12, SGPT 31, CEA 5.1 (normal 0–5.0).

The patient was evaluated with a bone scan and a CT scan of the abdomen, both of which were negative. Chest x-ray was within normal limits. The patient was taken to surgery. Figure 1 shows the mass at the time of operation. A biopsy of the mass and frozen section was

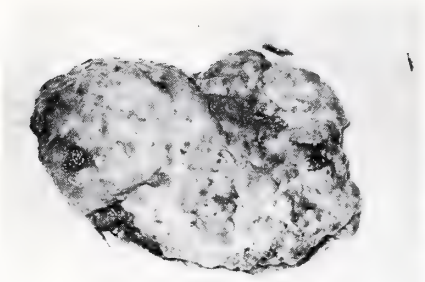


Figure 1
Appearance of the mass at surgery. The umbilicus is to the right.

performed, revealing a mucin-secreting adenocarcinoma. The mass was excised with a margin of normal appearing skin. The abdomen was opened through a midline abdominal incision; there was no evidence of metastasis. Approximately one foot of normal-appearing distal ileum was resected. The patient's ileostomy was then transplanted to the left iliac fossa. The patient's postoperative recovery was slow but unremarkable, and she was discharged on the tenth postoperative day. Twenty-two months following resection of this lesion, the patient remains apparently disease free.

Pathologic Description

The surgical specimen consisted of the ileostomy, a thin rim of surrounding skin, and a 25cm segment of ileum. The ileostomy was replaced by a large bulky mass of mucoid, friable tissue with a patent ostium in the center leading to the ileum. There was sharp demarcation of the normal bowel and the lesion of the ileostomy. Grossly, the invasion of the underlying tissue appeared superficial, without obvious involvement of the deep dermis of the skin or muscularis of the ileum.

Microscopically, the tumor was composed of irregular glands with mild-to-moderate pleomorphism of the nuclei. (Figure 2) In some foci there was abundant mucin production. (Figure 3) Invasion was relatively superficial, with invasion of the muscularis mucosa but not the muscularis of the bowel. No regional lymph nodes were involved. No evidence of polyps, inflammatory bowel disease or dysplastic changes were found in the segment of the ileum proximal to the tumor.

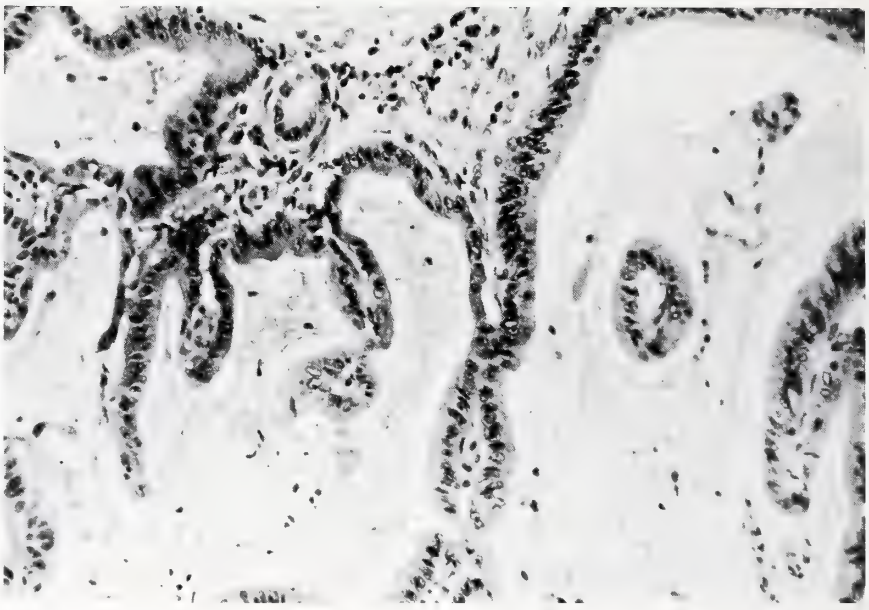


Figure 2
Photomicrograph showing mucin-secreting component of the adenocarcinoma with large lobes of mucin.

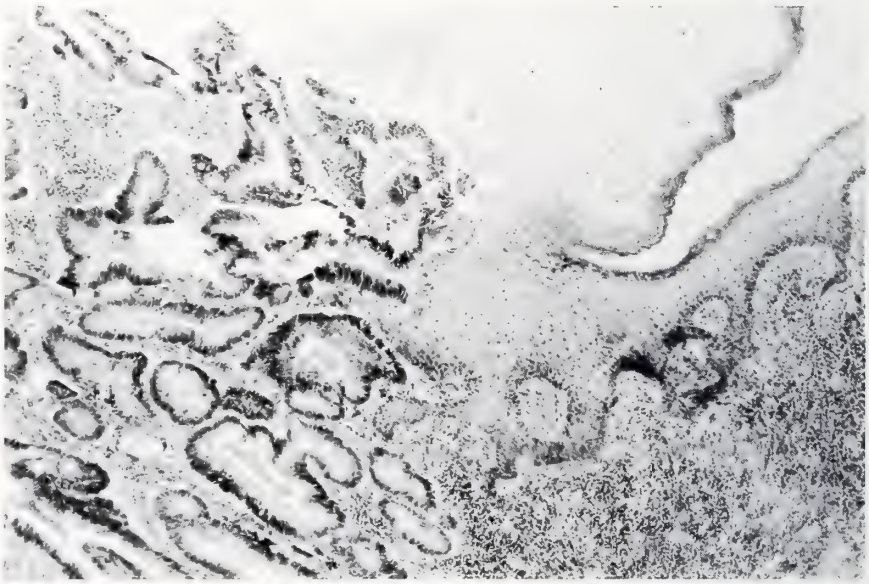


Figure 3
Photomicrograph of ileostomy site showing junction of normal skin and adenocarcinoma.

Discussion

Carcinoma arising in an ileostomy is a rare occurrence. To date only five cases have been reported in the English language literature. The present case report represents the sixth known case and the first to occur in a patient with familial pol-

yposis. The first report by Sigler and Jedd in 1969 was that of a 56-year-old female who developed an adenocarcinoma at the ileostomy stoma site 19 years after partial colectomy and ileostomy for ulcerative colitis.[6] The patient was treated by surgical resection and translocation of the ileostomy to the opposite side of the abdomen. Ten months after treatment the patient died with local and distant metastases. Metastatic tumor was found in the superficial inguinal lymph nodes as well as in the liver. Cuesta and Donner,[2] Stryker,[5] and Baciewicz and associates[1] have reported similar cases. Previously reported findings are summarized in Table 1. A report by Johnson and colleagues[3] probably represents an example of tumor auto transplantation rather than a primary carcinoma. Johnson reported a 39-year-old man who had undergone a subtotal colectomy and eventual ileoproctostomy for ulcerative colitis. Because of recurring proctitis and repeated small bowel obstruction, a permanent ileostomy was created and a proctectomy performed. Three years later the patient complained of swelling, pain and bleeding from the ileostomy. The distal ileum and ileostomy were resected and a diagnosis of well-differentiated, mucin-secreting adenocarcinoma was made. Re-examination of the previously-excised rectal specimen revealed a villose adenoma close to the previous anastomotic line. The adenoma contained areas of invasive well-differentiated adenocarcinoma.

Except for the report by Johnson, cases of carcinoma in an ileostomy have occurred in patients with long-standing ileostomies. All reported cases have been described histologically as well-to-moderately-well-differentiated mucin-secreting adenocarcinomas. Only one instance of metastasis has been described, that in a patient by Sigler and Jedd in which both regional and distant metastases existed.[6] In all other cases the tumors appeared to follow a slow, indolent course. A number of theories have been advanced concerning the etiology of this unusual malignancy. Since the previously reported patients suffered from ulcerative colitis, it was thought that dysplastic changes in the terminal ileum associated with "back wash" ileitis might lead to the development of a malignancy.[4,5] In the current report, the patient underwent proctocolectomy for familial polyposis. Histopathologic examination of the resected ileum did not reveal any abnormal features, specifically, areas of dysplasia or polyps. It is possible that chronic irritation of ileal stoma from an improperly fitted appliance or the repeated use of topical silver nitrate by this patient may have

Table I
Summary of Reported Cases

Author	Patient Age	Sex	Interval between Ileostomy & Diagnosis of Carcinoma	Underlying Disease	Presenting Symptoms	Histology	Treatment	Comment
Sigler & Jedd (1969)	56	F	19 years	UC*	Pain, mass	WD† mucinous adenocarcinoma	Resection of stoma & distal ileum	Dead of recurrent disease after 10 months
Cuesta & Donner (1976)	60	M	31 years	UC	Skin irritation	MD†† mucinous adenocarcinoma	Resection of stoma & distal ileum	Alive NED††† 9 months later
Johnson et al. (1980)	39	M	2 years	UC	Pain	WD† mucinous adenocarcinoma	Resection of stoma & distal ileum	Tumor probably transplanted from rectum (see discussion) No follow-up reported
Stryker (1983)	66	F	20 years	UC	Pain, mass obstruction	Adenocarcinoma "average grade"	Resection of stoma & distal ileum	Alive NED††† 7 years later
Baciewiez et al. (1983)	45	F	32 years	UC	Pain, induration of peristomal skin	MD†† mucinous adenocarcinoma	Resection of stoma & distal ileum	Follow-up not described
Ross et al. (1987)	65	F	32 years	FP**	Mass	WD† mucinous adenocarcinoma	Resection of stoma & distal ileum	Alive NED††† 22 months later

†WD = Well-differentiated
††MD = Moderately well-differentiated
†††NED = No evidence of disease
**UC = Ulcerative colitis*
***FP = Familial polyposis*

played an etiologic role. Another hypothesis is that suspected carcinogens known to be present in liquid ileal effluent[7,8] may be in contact with the externally-exposed mucosa for long periods of time.

The reported treatment for adenocarcinomas arising in ileostomies consists of resection of the stoma with a surrounding cuff of normal-appearing skin and a margin of normal distal ileum. In no case was it necessary to resect a portion of the abdominal wall. A new ileostomy is created by translocation to the opposite iliac fossa. No information exists in the literature concerning the role of adjuvant chemotherapy and/or radiation therapy. Although carcinoembryonic antigen was not elevated in our patient, it may prove to be a useful adjunct in long-term follow-up.

In summary, adenocarcinoma arising in an ileostomy appears to be a late and rare complication which occurs many years after creation of the ileostomy. Previously reported patients were diagnosed as having ulcerative colitis. The present report indicates that it may also occur in patients suffering from non-inflammatory conditions. These carcinomas appear to be bulky, slow-growing and apparently do not frequently metastasize. Treatment should include aggressive surgical resection of the stoma and surrounding skin, including a margin of normal ileum, and translocation of the ileostomy to the opposite iliac fossa. ◀

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How Much Do You Know About the New Illinois Medical Practice Act?

The Medical Practice Act governs much of your medical practice. It sets standards for your education, relicensure and even the type of care you can or cannot provide patients. It calls for discipline if you fail to meet its stipulations. It protects you from liability for your participation in peer review and certain patient care activities. It affords you a license to practice medicine here and sets the fees you pay for it.

A January 1987 Illinois State Medical Society survey showed that 94% of ISMS members knew little about this important law regulating physicians, osteopaths and chiropractors. How much do you know? Use the following quiz to test your Medical Practice Act acumen—and to shed some light on this law's importance in your day-to-day practice of medicine. See the following page for solutions to these questions.

1. Do you need continuing medical education for license renewal? _____
2. Are there any restrictions on physician advertising? _____
3. Must you label any drug you dispense from your office? _____
4. Can you be disciplined for failure to report suspected child abuse? _____
5. What special records are required when you dispense controlled substances? _____
6. Can state authorities inspect your offices? _____
7. How does state law address physician impairment? _____
8. Can you be disciplined for failure to transfer medical records? _____
9. What Illinois agency has authority for medical licensure and discipline? _____
10. How long should you save patient medical records? _____
11. Can you be disciplined for improper business practices which inconvenience but don't harm patients? _____
12. Are you protected against lawsuit when providing emergency care outside the hospital? _____

13. Are you protected against lawsuit when providing free care to indigent patients? _____

14. Must you take Medicare assignment as a condition of Illinois licensure? _____

15. Can you be sued for serving on a peer review committee? _____

16. What is mandatory reporting? _____

_____

_____

17. How many years of postgraduate education do you need for Illinois licensure? _____

18. If you dispense drugs from your office premises, what special rules must you follow? _____

_____

_____

19. Can physicians participate in screening and investigating complaints received by state licensure authorities? _____

20. Can you contract with your patient to release you from medical malpractice liability? _____

21. Can you accept a fee for referring a patient to another physician? _____

22. How can hospitals be assured that a medical staff applicant has not had his or her license disciplined in another state? _____

_____

The Solutions: How Much Do You Know?

1. CME Requirements

Yes, you must participate in continuing medical education programs to maintain your Illinois license. The Medical Practice Act, however, does not stipulate a minimum hourly requirement. It authorizes state licensing authorities to "promulgate rules of continuing education." When applying for relicensure, doctors must now answer the general question of whether they have participated in CME. State authorities have authority to conduct random audits to assure the validity of individual responses.

2. Physician Advertising

As evidenced by the plethora of radio, television and print promotions for doctors and related medical services, the Medical Practice Act does allow physicians to advertise. At the same time, it does restrict how advertisements are framed. The specific category of licensure (M.D., D.O., or D.C.) must be clearly stated. It is unlawful to use testimonials or claims of superior quality of care to entice the public. Nor can you advertise free comparison of available services with those of your competitors. False, fraudulent, deceptive or misleading material, or guarantees of success are also barred. Finally, physician advertisers cannot knowingly publicize that they will accept assignment by third party payors as payment in full, if it leads patients to believe that required deductibles

or co-payments are eliminated.

3. Labelling of Drugs Dispensed by Doctors

Yes, the Medical Practice Act says you must label drugs you dispense to patients. Labels should indicate the date of dispensing, name of patient, directions for use, the proprietary or established name of the drug, and the dosage and quantity. The labelling requirements do not apply to drugs bearing the manufacturer's label (if those labels are in compliance with state and federal laws).

4. Reporting Suspected Child Abuse

The Medical Practice Act specifically cites "willfully failing to report an instance of suspected abuse or neglect" as a reason for medical discipline. The law was further stiffened last year, when Senate President Phil Rock sponsored legislation to hold physicians' licenses accountable when a doctor, among other mandated health providers, is "named as a perpetrator" or "causes a child to be abused or neglected."

5. Special Records/Dispensing Controlled Substances

Federal and state laws mandate that doctors take special care in maintaining records and actual inventories of controlled substances. These requirements are not contained in Illinois' Medical Practice Act, but in other statutes. Many physicians have, however, found themselves subject to medical discipline for failure to exercise proper caution and control in dispensing and keeping records of these potentially dangerous drugs. If you are dispensing controlled substances from your office, be sure you know the law. ISMS has a brochure outlining federal and state requirements. It is available to members at no charge.

6. Office Inspection

Upon determination that a probable violation of the Medical Practice Act has occurred, Illinois' Medical Disciplinary Board may authorize investigators to inspect a physician's physical office premises. Investigators cannot inspect business, medical or personnel records without a subpoena. Recommended by the Governor's Task Force on Medical Discipline, this new Medical Practice Act provision is aimed at ferreting out illegal, nontherapeutic dispensing of controlled substances and the unlicensed practice of medicine.

7. Physician Impairment

Continuing, excessive and habitual alcohol and drug abuse are grounds for license discipline in Illinois. Doctors who have recognized their dependency and are undergoing treatment are closely monitored by state licensure authorities, rather than disciplined. But the law provides that doctors leaving treatment prematurely are automatically brought before the Medical Disciplinary Board for review. ISMS sponsors a confidential referral and counseling program to help impaired doctors regain their foothold before their licenses are threatened. ISMS does not report doctors using our program to state licensure authorities unless they are recalcitrant about receiving treatment and constitute a threat to patients.

8. Medical Records Transfer

Yes, physicians who fail to transfer patient medical records are opening themselves up to disciplinary proceedings.

9. Illinois Medical Licensure and Discipline Authority

The Illinois Department of Registration and Education is responsible for licensing and disciplining a wide variety of Illinois professions—ranging from hair dressers to doctors of medicine. Rewritten and updated during the last General Assembly session, the Medical Practice Act sets criteria for licensure and discipline which guides Department officials. The law establishes two boards which review physicians: the Medical Licensing Board looks at licensure requirements and applicants, and the Medical Disciplinary Board investigates physician violators, recommending disciplinary action where warranted. Both Boards are appointed by the Illinois governor and are comprised of physicians, osteopaths and chiropractors. In addition, two nonvoting public members sit on the Disciplinary Board.

10. Saving Patient Medical Records

The Medical Practice Act is silent on how long physicians should save patient medical records. Many legal experts agree that, at *minimum*, you should retain medical records until the statute of limitations for medical liability has lapsed. That means at least four years for adults and eight years for children. When a patient is mentally incompetent, the

Are You Hard To Find?

Can state authorities find you to give you your new license? The Department of Registration and Education reports that many licenses are returned as "undeliverable" because physicians have moved their office or home address without notifying state licensure authorities. The Department recommends that doctors use their most permanent address—whether office or home—on their licensure application. And don't forget to let the state know when you're making a move. Just write to the Department of Registration and Education, 320 W. Washington Street, Springfield, Illinois 62786. (After January 1, address correspondence to the Department of Professional Regulation.)

statute of limitations never runs out. Check with your attorney or malpractice insurance company to assure that you are not prematurely disposing of essential documents.

11. Improper Business Practices

The Medical Practice Act allows for fines against physicians who use improper business practices. State authorities can levy up to $5,000 against doctors whose business practices inconvenience, but do not harm, patients. The Illinois Governor's Task Force on Medical Discipline recommended use of fines to give the Department a broader range of appropriate disciplines, rather than just the ability to restrict a doctor's license.

12. Immunity for Emergency Care

You are afforded immunity under the Medical Practice Act when you render emergency care outside the hospital. Under this "good samaritan" provision, anyone licensed to practice the treatment of human ailments (excepting midwives) shall not be liable for civil damages. You must not have prior notice of the illness or injury, and you must not accept a fee.

13. Immunity for Free Care

You are immune from civil liability for providing free care only when your services are part of an established free medical clinic. You cannot receive compensation from that source or from any other business or professional activity connected with medicine. Essentially, physicians donating free care must be retired from the practice of medicine—or not otherwise receive any income from its practice—to qualify for immunity.

14. Medicare Assignment

No. A serious threat to mandate Medicare assignment as a condition of licensure was beaten back in the just-concluded session of Illinois' General Assembly. The legislation is likely to reappear next year. Only a handful of states have mandated Medicare assignment. ISMS will continue its staunch opposition to any such move in Illinois.

15. Lawsuit for Peer Review Activities

Nothing can prevent a citizen from suing you for your peer review activities. But the Medical Practice Act does protect you and your colleagues from civil liability while serving "in good faith" on any committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity and mortality, or for improving patient care or physician services within a hospital. Peer review activity under the auspices of a professional association is also protected.

16. Mandatory Reporting

Under this Medical Practice Act provision, any negative action taken against a physician's license or credentials must be reported to the state's Medical Disciplinary Board. Insurance companies are required to report settlements or court awards against physician policyholders; hospitals must report any restriction of medical staff privileges; county and state medical societies must report removal of a doctor from their membership ranks. These reports give state authorities valuable leads, enabling them to better investigate potentially incompetent, fraudulent or otherwise poor practitioners.

17. Residency Requirements for Licensure

Illinois' General Assembly, at the suggestion of ISMS, boosted residency requirements for doctors receiving Illinois licensure. Until January 1988, the law requires M.D. license applicants to have completed 12 months of postgraduate clinical training, as approved by the Department of Registration and Education. After that time, the requirement doubles to a minimum 24 months. ISMS believes that better quality medicine will spring from this tightened educational and training provision.

18. Drug Dispensing by Physicians

In addition to proper labeling, the General Assembly recently imposed several new mandates on doctors who dispense. First, physicians must offer a written prescription, should the patient choose to obtain the medicine elsewhere. Second, if the physician is not personally filling the prescription, medical office personnel can do so *only* under the doctor's direct supervision. Third, any doctor dispensing drugs must maintain a book or file of prescriptions dispensed, just like a pharmacist.

19. Physician Assistance for State Licensure Authorities

The Medical Practice Act allows state licensure authorities to deputize physician review panels to help screen and investigate complaints, and recommend appropriate discipline for violators.

20. Contracting to Avoid Liability

You cannot make any contract with your patient prior to, or as a condition of treatment, which releases you from medical malpractice liability. According to the Medical Practice Act, any such contract is "void and against the public policy of the state of Illinois."

21. Fee Splitting

Dividing fees or compensation with anyone other than your professional partners is against the law. The Medical Practice Act prohibits any fee, commission, rebate, or other form of compensation for services not actually and personally rendered.

22. Checking Physicians' Credentials

Both the Medical Practice Act and the Hospital Licensing Act include a new provision mandating that hospitals aggressively search out a physician's credentials and disciplinary history from the Illinois Department of Registration and Education. This check must be completed before admitting any doctor to a medical staff.

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A Personal Reflection on Coping

By Teresa Schmidt/O'Fallon

I'm sitting in the I.C.U. waiting for the next time I may spend a few minutes with Grandma. She is 88 years old and has just experienced her first heart attack. The damage was extensive and there will probably be more attacks to come. She knows this and so do I. Grandma is coping like a pro and I'm trying to cope. In fact, I'm doing rather well, and I can thank Grandma for that!

This lady, who let me whittle on sticks with her kitchen paring knife and wash clothes with her old-fashioned wringer washer, and who filled my bath tub with soft hand-drawn well water, is my mentor, my teacher, my friend. She has always, to my knowledge, been able to find the right tools for any job and "get by" or "make do."

Getting by or *making do* are country phrases for "coping." I'd ask Grandma, "How did you get by when such and such happened?" Sometimes she would say, "I don't know honey, but I managed. I just made do." And that's the trick—to just do it. You don't learn to cope, get by, or make do without practice. It takes a lifetime to become a pro like Grandma. So I'm practicing now, and I'm improving, but I'm not half as skilled as she is.

What would Grandma say to me now, while I'm wondering if I can endure this crisis without crumbling to pieces? She would probably say, "Reset your sights—your sights are too high." That's just another country way of saying, "Readjust your expectations and priorities for yourself." Or, "You expect too much of yourself."

I've always struggled with setting my sights fairly. But so has most of the world. And, for those of us who are physician spouses or family members, role expectations can be very difficult to achieve.

One of our role expectations is to become involved in the health related issues of our community. This year ISMSA will be following the example set by the AMA, which is to focus attention upon its "Adolescent Health Initiative." The problems are many and familiar: teen pregnancy, substance abuse, eating disorders, violence, and suicide. It seems that central to all these issues is the inability of teenagers to cope with what life deals them. Unwillingness to readjust expectations, to find alternatives, to persist faithfully are the disease entities, while pregnancy, substance abuse, eating disorders, violence, and suicide are the presenting symptoms.

Grandma used to talk about solving problems by "looking for the root." Having identified it, she would "nip it in the bud." It appears that failure to teach coping skills to our children and offering them opportunities to practice their skills is the root of the problem here.

As we feel surrounded by so many crises, to suggest one focus towards a solution may seem rather

The accompanying article will be published in the January 1988 issue of the AMAA *Facets*. Coping and values will be central themes stressed in our Adolescent Health Program.

Friday, November 6, ISMSA will sponsor a seminar on Adolescent Sexuality at the Hyatt Oakbrook, which will be open to all health, psychological and social educators who work with adolescents. Our members are invited and any physicians who wish to attend can call ISMSA at 312/782-1654 for information or to register. (A $30 fee for members includes lunch.)

Lynn Kassel
ISMSA President

naive. Yet, from a preventive medicine point of view, to look towards positive actions that may avert the negative reactions currently displayed by today's youth seems only logical. To fragment our resources and concerns into exclusive areas of teenage health will prove to be costly in time, effort, money, and lives. Teenage suicide, substance abuse, pregnancy, violence, and eating disorders all share a key component . . . the inability to cope, "get by" or "make do."

Our children must see coping skills in action, in parents as we struggle daily, in literature, and in themselves as they plan their futures. We must allow our children to stumble in their endeavors and sometimes fail. We must then help them pick themselves up, dust themselves off and try again. To have a light in one's life or to be able to see "the light at the end of the tunnel" is to be able to cope.

One must find success in perceived failures and realize that we will all fail more often then we will succeed. Each crisis, each hurdle, provides us an opportunity to either perceive dismal failure or to take advantage of a chance to grow.

Surely, we auxilians will not limit our focus to fragmented teenage health related issues. Hopefully, we will be able to look a little deeper so as to address the central issue of coping. For at this moment, in the I.C.U. waiting room, it is that core of coping that keeps me going. I thank Grandma for that central core within me. But how can I ever thank her? I plan to tell her, next time I see her, "No matter what happens with you Grandma, it's okay with me." I'm certain she'll say, "Thank you, honey."

Editor's Note: The author is chairman of the ISMSA Teen Suicide Committee. Her grandmother passed away earlier this summer.

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Subtleties and Nuances of the Democratic Process . . .

A Firm Grasp of the Big Picture

Legislative review is a complex process that begins and ends with counting votes. Grassroots involvement in local races elects lawmakers willing to listen to medicine's message. Consistent support between elections encourages communication as individual bills are considered. Laws take form in a complex two-step of legislative give-and-take which, though eminently fair, moves at its own pace and in response to its own needs. Success is closely tied to negotiating skill, timing, personalities, and above all, a firm grasp of the big picture.

The Illinois General Assembly began its 85th session on January 13,1987, according to the mandate of the state constitution. Several proposals affecting the profession were up for debate, including three of overriding importance. The Illinois Medical Practice Act, which touches on every aspect of the physician's work, would undergo a complete rewrite under sunset review. And two crucial medical malpractice reforms would be proposed: caps on noneconomic damages and a revised statute of limitations for cases involving minors.

Leadership also plays an important part in determining where votes may fall on a given issue. In terms of tort reform for example, both House Speaker Michael J. Madigan (D-Chicago) and Senate President Philip J. Rock (D-Oak Park) had taken a hard line against most tort reform proposals.

Speaker Madigan wields tremendous influence over the Democratic members of the House. Only a handful of his party's members dare to refuse when he asks for a vote on an issue which he considers important. Senate President Rock is less inclined to apply pressure on particular votes, although he will advance strong arguments to support his position.

The Republican leaders in the General Assembly, Lee Daniels (R-Elmhurst) and James "Pate" Philip (R-Addison), have a great deal of influence over their members in the House and Senate. This tends to be true of most minority party leaders in legislative bodies. Minorities, if they do not stick together on most issues, tend to lose their leverage. They then run the risk that the majority party will run roughshod over all of their interests.

Democrats controlled the House 68 to 50, and the Senate 31 to 28. Only a small portion of the roll calls taken in either house will reflect strict partisanship, and medical issues usually do not raise partisan haggling. This had not been true however, of the ISMS tort reform efforts. In 1985, Republicans had

generally supported the comprehensive proposals advanced by ISMS. Democrats were generally opposed.

Similar partisan alignment had been seen in 1986, when 150 associations formed an organization known as the Illinois Coalition on the Insurance Crisis (ICIC) to advocate significant tort reforms. Many of those proposals were identical to the ISMS package passed the previous year.

A Foreshadowing: The ICIC Experience

The ICIC was led by some very powerful interest groups in the state: the Illinois Manufacturers Association, the Illinois State Chamber of Commerce, the Illinois Retail Merchants Association and virtually anyone else who had difficulty affording or even obtaining liability insurance.

While physicians had experienced the liability crisis for over ten years, the business community and local governments had only recently encountered it. Businesses and local governments had experienced 1,000% premium increases in 1985. In some instances, this 1,000% increase had purchased only 50% of the prior coverage. Shock waves raged through business and industry, producing a high-pitched call for tort reform. The business community was confident that the legislature would support their efforts, given medicine's success in the previous year. They reasoned that if one group (physicians) could push through a package of bills, then 150 groups together could achieve the same goal.

The ICIC legislative strategy in 1986 differed significantly from the 1985 ISMS strategy. The ISMS strategy had been based on an early grassroots effort, beginning in home districts before the legislature convened and continued through the session with consistent physician-legislator contact and a Springfield rally of approximately 4,000 physicians.

The ICIC, on the other hand, did not apply early grassroots pressure prior to the 1986 legislative session. Instead, they introduced bills just prior to the deadline and then mounted an intensive campaign. Opposition was strong. The Illinois Trial Lawyers Association, labor groups and the Illinois Public Action Council strenuously lobbied to defeat these bills.

Amendments offered to the eventual bill contained provisions similar to ISMS tort reform proposals passed in 1985. These included collateral source offsets, changes in awards for punitive damages and limitations on attorney contingency fees. The ICIC also sought to cap awards for noneconomic losses in all tort cases. While several proposals were adopted, the amendment to cap awards for noneconomic losses fell four votes shy in the Senate.

As the ICIC bill made its way through the Senate and over to the House of Representatives, it became clear that the issue was too hot to be avoided. Speaker Madigan called together all interested parties in an effort to negotiate a compromise. Negotiations continued for several weeks with no apparent headway. Both sides dug in their heels and simply would not budge. As the session drew to a close, a conference committee report was prepared by the Speaker's staff to provide for limited tort reform.

This would be the only 1986 vote in the House on tort reform. The ICIC lobbied against the conference committee report, believing that they were better off with nothing than with watered down proposals which would not effectively address the situation and might make it worse. But in time, the conference committee report was easily adopted and sent to the Governor. The Governor signed the bill despite the ICIC plea for a veto.

The experience of the ICIC tort reform efforts in 1986 gave ISMS a preview of the possibilities for additional medical malpractice tort reform legislation in 1987. What ISMS learned was that the opposition was far better organized against the ICIC than they had been against ISMS the previous year. It became obvious that Speaker Madigan would not allow votes on specific tort reform proposals but rather would institute a negotiation process that would result in an agreed bill. Finally, it was soon apparent that caps on awards for noneconomic losses in tort cases did not have the support of a sufficient number of senators to pass. These three facts combined to paint a gloomy forecast for the probability of any further and significant tort reform.

The 1987 Experience

Following enactment of the Medical Malpractice Reform Act of 1985, ISMS had promised to return to the legislature to seek additional reforms, including a cap on awards for noneconomic losses. Malpractice awards had continued to soar and insurance premiums to skyrocket. ISMS moved ahead with the proposal and caused its introduction into the 1987 session of the Illinois General Assembly. Proposed caps drew intense opposition from the Illinois Trial Lawyers Association and other opponents of tort reform. While ISMS believed, and still believes, that a $250,000 cap is one of the most effective ways to address the malpractice crisis, plaintiff attorneys and others insisted that such a proposal was intrinsically unfair and unnecessary.

Medical Practice Act Rewrite Enters the Picture

Caps on awards for noneconomic losses was not to be the only major issue for ISMS in 1987. In fact, there were numerous major issues in this session, including reduction of the statute of limitations for medical malpractice cases involving minors. Most significantly, the Medical Practice Act was scheduled for automatic repeal on December 31, 1987.

The required rewrite of the Medical Practice Act posed some very difficult problems for ISMS. Opponents of tort reform had a perfect opportunity to advance legislative objectives and divert ISMS attention from other goals.

From the time of the 1984 Professional Liability Initiative, plaintiff attorneys and other opponents had continually raised the issue of medical discipline. They had pointed to government studies suggesting (in their eyes) that physicians were not policing themselves as they should. Their solution to the malpractice problem was to discipline

physicians who were being sued. More than a dozen bills were introduced to that end.

The Illinois Public Action Council and the Coalition for Consumer Rights proposed bills to require every licensed physician to carry at least a $500,000 malpractice insurance policy; raise physician licensure fees to $500 per year; require physicians to report all instances of unprofessional conduct by other physicians; and increase the number of public members on the Illinois State Medical Disciplinary Board from two to four and allow the public members a vote.

Lastly, the Illinois Public Action Council, along with the Illinois Council of Senior Citizens, introduced a bill that immediately drew the attention of all Illinois physicians. That bill, HB 815, would have mandated assignment of all Medicare claims.

While there is no doubt that these groups were serious about passing the mandatory assignment bill, they also must have realized that this particular bill would bring a fierce response from ISMS, diverting energies away from tort reform. They suggested that since we were attempting to cap awards, proposing caps on physician fees was only fair.

When the House Select Committee on Aging heard the mandatory assignment bill, the proceedings clearly exposed a strategy designed to bring ISMS to the negotiating table. Although tort reform and the rewrite of the Medical Practice Act were totally separate issues, their concurrent legislative consideration clearly intertwined their fates.

In the weeks prior to the Committee hearing, ISMS lobbied strongly against the bill. A head count of the Committee indicated that a majority of members did not support mandatory assignment. But it became clear on the day of the Committee hearing that Democratic leadership wanted this bill to reach the floor of the General Assembly. Lobbying against it would occupy physicians' time and effort. After a good deal of procedural wrangling, the bill was reported out of committee. Now the full House would determine the fate of mandatory Medicare assignment.

Democratic leadership had indicated to ISMS that they were interested in seeking a compromise on all the medical issues before the General Assembly. In plain terms this meant that caps would not be considered by the General Assembly and that the Medical Practice Act proposed by ISMS would be given broad support.

The Big Picture

The ISMS Ad Hoc Committee on the Rewrite of the Medical Practice Act had labored long and hard to develop proposals that enhanced the disciplinary process. Proposals dating to the 1984 Task Force on Malpractice had been weighed and incorporated. Many were unique. The bill also had the strong support of the Department of Registration and Education and Governor Thompson. Impartial observers believed that its adoption would give Illinois the most innovative medical practice act in the nation.

The proposed Medical Practice Act was clearly an attractive bill, which most, if not all, legislators could support. On the other hand, a head count of those favoring caps on noneconomic awards continually came up a few votes short. At best, only 56 representatives could be counted on to favor this particular bill. Even a few of these votes were waivering. The odds on getting the needed 60 votes appeared indeed quite long.

ISMS leadership now faced a very difficult decision. Negotiating with legislative leadership would almost automatically mean conceding caps. It might also mean completion of the Medical Practice Act rewrite with little difficulty—and without onerous provisions sought by consumer groups and others. Both the Act and caps were extremely important to Illinois physicians. But it was becoming apparent that caps could not pass this session.

No interest group descending on Springfield gets everything they want. Politics is the art of compromise. Legislative leaders expect competing interest groups to negotiate and compromise, especially on controversial issues. The ICIC had learned this in 1986.

Negotiations on medical issues before the General Assembly boiled down to two major issues, caps and the rewrite of the Medical Practice Act. ISMS demanded that its proposal to rewrite the Medical Practice Act be kept intact, and not include any mandatory assignment provision. Adversaries then demanded that the proposal to cap noneconomic awards be dropped. All the bills which ISMS opponents had introduced to regulate the insurance industry, amend the Medical Practice Act or otherwise have an adverse impact on physicians were also to be dropped.

ISMS had demanded that serious consideration be given to a change in the statute of limitations for minors as it relates to medical malpractice cases. Senate President Phil Rock had already indicated his support for some change. Speaker Madigan was not enthusiastic about this proposal but at least three of the legislative leaders supported some change. Language was drafted to change the law. What resulted was a significant amendment to the Code of Civil Procedure that will lend some predictability to lawsuits involving minors.

With agreement on this issue the log-jam of legislation began to flow. The House Registration and Regulation Committee unanimously approved the Medical Practice Act rewrite. Final approval in each chamber came swiftly and unanimously. And on May 22nd, Governor Thompson signed the Medical Practice Act of 1987 into law.

Conclusion

Development of the 1987 Illinois Medical Practice Act began during the 1984 Professional Liability Initiative and continued through early proposals by the Task Force on Malpractice and the Governor's Task Force on Medical Discipline. Its path through the General Assembly provides a classic illustration of the democratic process at work.

ISMS leaders are committed to a return in search of caps on noneconomic damages in 1989, a process that begins with respect for the system, early grassroots education, local involvement in the 1988 elections and a firm grasp of the big picture. ◀

The Illinois Medical Practice Act

An Accomplishment That Remains Incomplete

By Alfred J. Clementi, M.D./Arlington Heights
Chairman, Governor's Task Force on Medical Discipline
Chairman, ISMS Ad Hoc Committee on the Medical Practice Act

The new Medical Practice Act, recently passed and signed into law by Governor James R. Thompson, represented a realignment, a renewed commitment, and a classic exercise of the legislative process.

The rewrite and its passage completed three years of study and work to reform physician discipline. The question of physician discipline had resurfaced in 1984, during the ISMS Professional Liability Initiative. The Task Force on Malpractice, along with its tort reforms, suggested that physicians look at the process of discipline in Illinois and make appropriate changes.

The state has responsibility and authority for these activities, and not ISMS, despite a common misperception to the contrary among members of the public. Still, I have always believed that physicians have a continuing obligation to re-evaluate how discipline is taking place and what improvement we can suggest in the process.

The Task Force on Medical Discipline was appointed, at the Governor's request, in 1985. All physicians were given an opportunity to comment on how discipline occurred and what improvements were needed. As chairman of that Task Force, I sought input throughout the process.

The physicians met with members of the Department of Registration and Education, including the director, Gary Clayton, and developed a new Medical Practice Act which was introduced in 1986. The attempted rewrite was unsuccessful but it gave us a nucleus for the following year when "sunsetting" of the Act would occur. ("Sunsetting" is a legislative mechanism which imposes automatic expiration dates for specified laws. It is designed to force legislators to review statutes, ensuring that they remain current and pertinent.) We learned some hard lessons in that delay of the rewrite, but it is my opinion that what we attempted was worth the effort. The political powers in Springfield weren't about to let us rewrite the Act a year early to avoid sunsetting.

I was appointed chairman of an ISMS ad hoc committee on the rewrite by Dr. Alfred J. Kiessel, the chairman of the ISMS Board of Trustees. Those on the committee included Drs. Kiessel, Decatur; Jere E. Freidheim, Burr Ridge; Allan L. Goslin, Streator; Lawrence L. Hirsch, Northbrook; Harold L. Jensen, Harvey; Morgan M. Meyer, Lombard; Pedro A. Poma, Melrose Park; Arthur R. Traugott, Urbana and Charles K. Wells, Mt. Vernon.

We were to study the Act and make adjustments so that those who had not supported the first rewrite would be comfortable with the overall approach. The committee met from July 1986 to January 1987 and developed a series of 10 drafts, some of which were circulated to the general membership via county medical societies.

Need for Perspective

When looking at the Act, it is important to remember that it was last completely rewritten in 1923. There have been modifications, many recommended by ISMS, but the basic document has been law for more than 60 years. While the Medical Practice Act governs how MDs, osteopaths and chiropractors are licensed and disciplined, its ultimate objective is to ensure that the public receives quality health care.

This presented the need for a discipline process that would effectively deal with "bad" doctors in a fair way, one which would respect the rights of all accused doctors. This commitment is ongoing. When we see weaknesses in the system, physicians should be the ones to recommend change. Physicians must be prepared to testify and, if necessary, sit in judgment of their peers. Peer review is a crucial key to an equitable discipline system. Absent our participation, the system cannot provide an evaluation of competence or performance; it can't even provide due process.

The Illinois Department of Registration and Education is the state agency responsible for implementation of the Medical Practice Act. Understanding the Act is perhaps easier when you divide it into its two primary components—licensure and discipline. Then it boils down to the license to practice—how you get it and how you can lose it.

Part One: Licensure

The Department of Registration and Education, through the Medical Practice Examining Committee (consisting of seven members: five MDs, one osteopath and one chiropractor), is responsible for granting and relicensing those subject to the



Illinois Governor James R. Thompson and ISMS leaders at a signing ceremony for the new Illinois Medical Practice Act and legislation reforming the statute of limitations for medical malpractice cases involving minors. Looking on (L-R) are Robert C. Hamilton, M.D., Chairman, ISMIS Board of Directors; Edward J. Fesco, M.D., ISMS President; Alfred J. Kiessel, M.D., Chairman, ISMS Board of Trustees; Fred Z. White, M.D., Chairman, ISMIE Board of Governors; and Alfred J. Clementi, M.D., Chairman, Task Force on Medical Discipline.

Act.

The Act establishes the educational requirements for licensure of MDs, osteopaths and chiropractors. This includes curriculum and clinical training, and examination criteria for licensure.

A physician meeting the initial requirements is granted a license subject to relicensure every three years. The change most discussed before the ad hoc committee was the length of time to be served in a residency prior to eligibility for full licensure. In the past, medical school graduates had been granted a two-year temporary certificate to practice within a program of post-graduate clinical training. After completing the first year of residency, the resident could apply and receive status as a fully licensed physician.

Some states require that graduates of foreign medical schools serve a longer residency period. This was proposed last year by the Department of Registration and Education. The Department suggested a three-year residency for foreign graduates due to the difficulty (if not impossibility) of providing Medical Licensing Board evaluation of each and every medical school. The Department believed that a longer period of residency training would allow those responsible for the training to better evaluate the basic education received at a medical college in combination with clinical training. That proposal met with a great deal of opposition. The Society adopted the position that all physicians, regardless of place of birth or training, should be treated equally. A compromise of two years for all graduates resulted.

The ad hoc committee recognizes that this is a higher standard than applies in other states. While some states require additional years of residency for all graduates, or require three years for foreign graduates only, Illinois is the first to require two years for all applicants for full licensure.

Another recommendation of the ad hoc committee clarifies the authority of the Medical Licensing Board to grant conditional licenses. For example, the Licensing Board could grant a license to an applicant on the condition that the applicant participate in a drug rehabilitation program. Participation would be monitored by one of the two proposed medical coordinators. Should a participant drop out of a program, the Medical Disciplinary Board would have the authority to revoke or suspend that license.

Licensure Fees

The funds that the Department receives from physicians are earmarked to pay for the administrative costs of renewing licenses and the over-all operation of the Medical Disciplinary Board. Illinois is among a minority of states where these fees do *not* go to general revenues which support other activities. They are funds earmarked for physician licensure and discipline. In fact, these fees do not fully support the licensure and disciplinary process; funds from general revenue are needed to subsidize the functions required under the Act.

The ad hoc committee debated licensure fees at great length. The Department of Registration and Education had originally proposed a relicensure fee of $130 per year, arguing that the new amendments warranted that amount. The ad hoc committee felt that this was a bit excessive. This issue was discussed with the governor's office, and the Governor adamantly insisted upon a renewal fee of $100. The fee for non-residents' licenses would be set at $200 per year. New applicants, who currently pay $150, would pay $300. Temporary license fees increased from $25 to $100. These fees are consistent with what is being charged across the nation. The Task Force believed that adequate funding was essential to a quality system.

The Medical Disciplinary Board

The discipline component of the Act functions under the authority of the Medical Disciplinary Board which oversees investigations into possible violations. Grounds for discipline are written into the Act to guide the Board and the Department in their work. The Board conducts hearings regarding the findings of these investigations and recommends disciplinary action to the director of the Department of Registration and Education. He has the ultimate authority to revoke, suspend, or otherwise restrict a physician's license.

The Disciplinary Board, made up of five MDs, one osteopath, one chiropractor and two non-voting lay members, may recommend a variety of disciplinary actions to the director beyond revoking, suspending or placing a physician's license on probation. They may recommend a reprimand, a restriction—such as a prohibition against prescribing drugs—or mandate participation in a drug abuse treatment program.

Equally important are those cases in which the accused is exonerated by the Board's thorough review. Investigations and initial screening proceedings are confidential to protect the professional reputations of those against whom complaints later are proven unfounded. However, formal hearings and actions taken by the Board are a matter of public record, and formal hearings and business meetings are, by law, open to the public.

Assisting the Board is a medical coordinator, who must be a fully licensed physician, and trained investigators, as well as other departmental staff. Investigators must be college graduates with at least two years of investigative experience or at least one year of advanced medical training.

Task Force Findings

The Governor's Task Force on Medical Discipline was a natural result of efforts which had begun back in 1984. Their recommendations on the disciplinary process, for the most part, were incorporated into the rewrite suggested by the ad hoc committee. Perhaps a review of those recommendations is the best way to highlight the changes in the disciplinary process that are included in the rewrite of the Medical Practice Act. Features incorporated into the Medical Practice Act from the Task Force on Medical Discipline included:

- Enhanced peer review capability through the creation of an additional M.D. medical coordinator. Medical coordinators in Springfield and in Chicago will provide better staffing for the Medical Disciplinary Board and

more effective peer review.

- Additional time to investigate and act upon complaints. Quality investigation is essential to weed out the few bad physicians and protect good physicians.
- Greater access to patient medical records with a proviso that patient names and identifiers are first eliminated. (Keep in mind that in order to gain access to a patient's record without the patient's consent, the Board must find probable cause that a violation exists.)
- Automatic review of impaired physicians who drop out of mandated therapy.
- Strengthened, expanded and clarified grounds for discipline to bring our Act into compliance with the model medical practice act of the Federation of State Medical Boards.
- Authority to impose fines to penalize continually inappropriate practices unrelated to the quality of care delivered to patients.
- The Board's ability to order an appropriately qualified investigator to enter the business premises of the licensee with due consideration for patient care to inspect the physical premises, equipment and furnishings therein. A determination that probable cause of violation exists, must be present. This order does not include authorized right of inspection of business, medical or personnel records, and is valid for only five days.
- A requirement that hospitals aggressively search out previous actions which may have been taken against a physician's license prior to accepting or renewing staff privileges.

The Politics

Sunset review provides a classic model for the legislative process at work. Early in the legislative session, some began to talk about attaching mandatory Medicare assignment to the Medical Practice Act so that doctors would be forced to accept assignment as a condition of licensure, as had happened in Massachusetts. The state legislative committee of the American Association of Retired Persons opposed this bill in Illinois, as did others who represent the medical population.

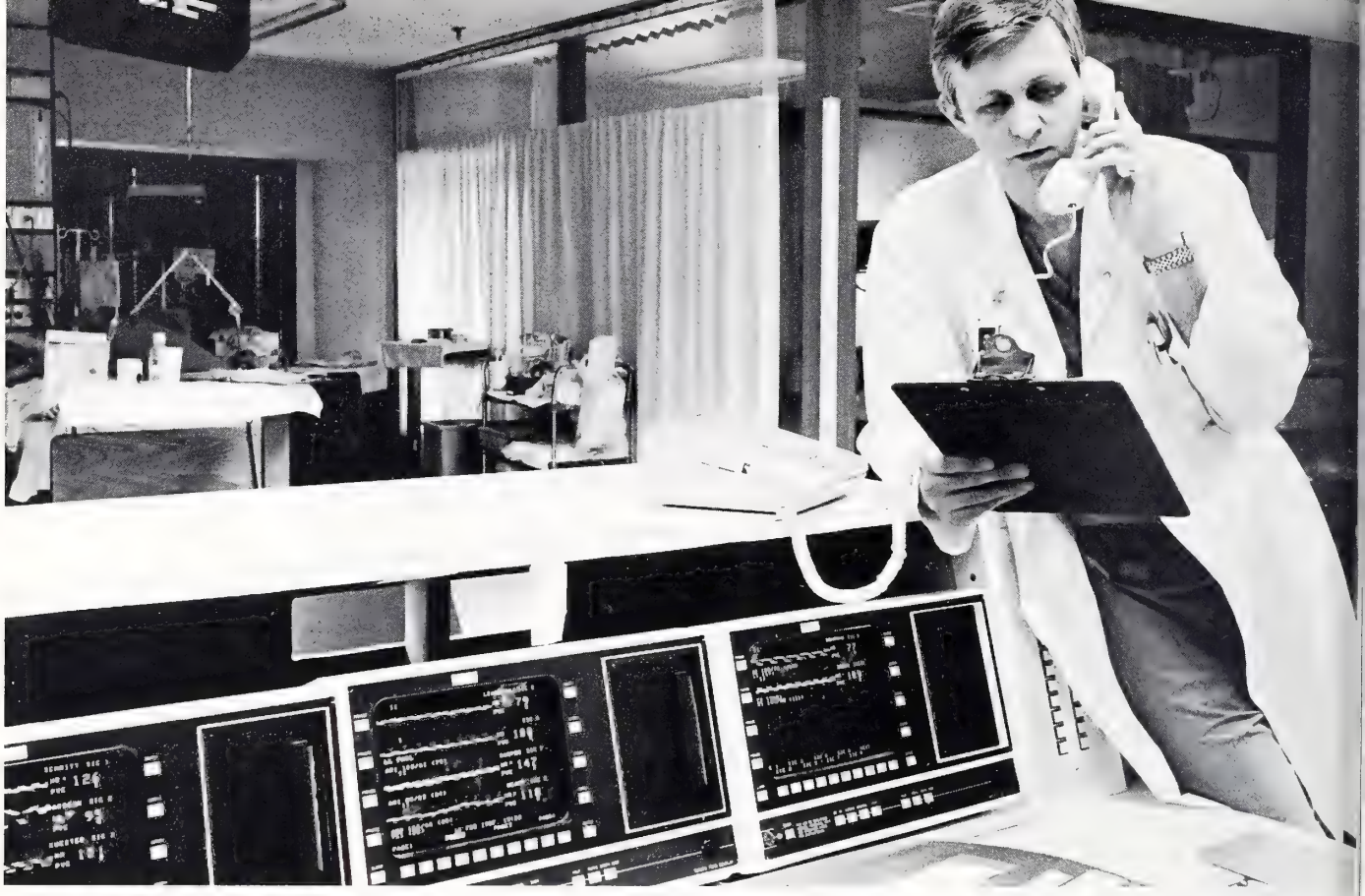
Others proposed mandatory retesting for medical licensure, open access to peer review records (which are currently confidential under the Act), a $500 yearly fee, and automatic license revocation or suspension based upon a predetermined number of malpractice suits filed or settled. There were many other proposals—many unfair and short sighted.

The legislative process provides opportunities to non-physician groups to amend the Act with provisions unrelated to the delivery of quality care. Review of statutes governing others in the health care field provides opportunity to expand their scope of practice, not through increased standards in educational requirements or training, but through legislative edict.

Those who wanted to defeat our malpractice reforms fanned the flames under the banner of consumerism. Recently I participated in a television debate when an attorney suggested that our avoidance of mandatory Medicare assignment had something to do with quality of medical care. Anyone who thinks he can make that case must have successfully used this type of logic to convince a jury. God help the tort system in America!

My last comment is to encourage all doctors to get involved in the election of their local legislators. We cannot simply claim that legislators are non-responsive if we don't work to support or not support them. That's what makes them responsive. ISMS can chart the political course, but individual doctors must take up the call to action by working with their local legislators. ◀

Alfred J. Clementi, M.D., chaired the Governor's Task Force on Medical Discipline, and the ISMS Ad Hoc Committee on the Medical Practice Act. Dr. Clementi is a member and former chairman of the ISMS Board of Trustees and a current director for Illinois State Medical Insurance Services, Inc. (ISMIS). He is a former president of the Chicago Medical Society as well as current chairman of the ISMIS Loss Prevention Committee. A board certified surgeon, he is a former medical staff president and department of surgery chairman at Northwest Community Hospital, Arlington Heights.



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The Illinois Medical Licensing Board

By Lawrence L. Hirsch, M.D./Northbrook

A license to practice medicine is granted, or withheld, as an exercise of the state's constitutionally mandated authority. Careful evaluation of applicants' skill and knowledge protects the public health. And because the unique interpersonal relationship between doctor and patient is so vulnerable to abuse, it is imperative that physicians be persons of integrity.

The license to practice medicine confers a property right, of sorts, which necessitates detailed rules of procedure to encumber or revoke. The Medical Practice Act establishes strict requirements for medical licensure.

Governmental licensing of physicians did not become common until the late nineteenth century. The concept was spurred by a fledgling American Medical Association and received wide public support. Westward growth of the nation, postwar economic adjustment, and massive social mutability highlighted the need to protect ailing patients from the clutches of self-appointed or poorly trained practitioners. When the Flexner Report appeared in 1910, state legislatures responded with measures of varying effectiveness. Illinois' record was rather commendable, probably resulting from legislative cooperation with the Illinois State Medical Society and other interested groups. The recently enacted Medical Practice Act of 1987, scheduled to "sunset" in ten years, was also fashioned with this multilateral input. All things considered, it is a well balanced law.

Under the Medical Practice Act of 1987, signed into law May 22, the Medical Licensing Board (previously known as the Medical Practice Examining Committee) recommends criteria for physician licensure and oversees the licensing process for individuals. This board is composed of seven members: five doctors of medicine, one doctor of osteopathy, and one doctor of chiropractic. One of the five M.D.'s must hold the rank of professor in a clinical department of an Illinois medical school. All are appointed by the governor "with the advice and consent of the Senate." In Illinois, osteopathic and allopathic physicians are eligible "to practice medicine in all its branches"; chiropractic physicians are eligible "to treat human ailments without the use of drugs and without operative surgery."

While the Board recommends candidates for licensure, the final decision lies with the Director of the Department of Registration and Education. (Effective January 1, 1988, the department will be called the Department of Professional Regulation.) However, the director cannot exercise any "functions, powers, or duties" with respect to licensure and examination "except upon review of the Licensing Board."

For those who may not be familiar with legislative language and practice, it is well to keep in mind that statutes contain intent as well as specifics. Specific statements must be expressly followed while legislative intent is interpreted and implemented by the executive branch via regulations. No regulations have yet been promulgated consequent to the new law, although there is vigorous activity in Springfield to this end. As is required, the regulations will be available for public review and comment before they take effect. Any interested party may challenge regulations during the comment period, and through the judiciary system after they are in place.

It is clear, from the mechanical construction of the statute, that the three disciplines addressed—medicine, osteopathy, and chiropractic—are meant to be treated in a parallel manner, although there are significantly different specifics throughout. This discussion will apply primarily to applicants for a license to practice medicine in all its branches.

The Licensing Board makes five

determinations in regard to each person seeking a license to practice medicine in Illinois. Most of the necessary information is furnished by the applicant on forms prescribed by the department. The first is that of United States citizenship or lawful entry into the country, either of which is necessary and relatively simple to ascertain. The second determination is more involved—that of an applicant's moral character. Conduct or activities which would be grounds for sanctions by the Illinois Medical Disciplinary Board must be considered and can lead to refusal or limitation of licensure. On the other hand, endorsement from licensees in good standing as to the applicant's qualifications and character is sometimes accepted as evidence of eligibility.

A third determination has to do with education: premedical, medical, and graduate. This can be a most difficult process and reasonable persons can differ. The new statute gives the Board significant discretion based on considered professional opinion, documentation, and some specific legal requirements. Throughout this deliberation two principle concepts must be in the forefront, fairness to the applicant and safeguarding of the public.

Having progressed this far, the fourth determination is that of capability of the petitioner to practice. There must be satisfactory evidence that the applicant is physically, mentally, and professionally capable to exercise judgment and skill with an appropriate degree of safety. A personal interview is sometimes required. In other instances, limitations or stipulations may be imposed on the license. The Board may compel submission to a mental and physical exam, and may condition any license commensurate with deficiencies revealed. If the two years previous to application have not been in active medical practice or in a formal educational program, the Board may require additional training or remedial education.

Step five is to determine, by written or other examination, whether the applicant has an adequate knowledge of medicine. It is left to the Board's discretion whether a standard exam will be accepted or whether some other reasonable device will be used. Under some conditions, at the Board's discretion, no examination is necessary. Fees for any testing must be borne by the applicant in addition to fixed statutory fees for processing and issuing a license.

The term "eminence" refers to the Department's discretionary authority to issue a license without examination. Specific criteria and educational requirements apply to licensure under these conditions.

Limited Licensure

In addition to full licensure, there are two types of temporary permission to practice medicine in a confined scope. The first, issued for purposes of pursuing graduate education in an accedited institution, is valid for up to three years and may be extended to complete a full residency. "Moonlighting" is expressly prohibited under this permit and is cause for revocation. The second special certificate is for those situations where an outstanding expert is brought to an educational setting as a visiting professor. The visiting professor must maintain his native license during the permit period. The permit, valid for one year, may be renewed once. Patient care is limited to that conducted in the teaching context.

Continuing Medical Education

Designing rules for continuing medical education, and determin-

License Renewal

Licenses are issued for a three year period, beginning August 1, 1987. Renewal is required during the month preceding expiration, with payment of the required fee. The Department mails the license renewal application to the last known address. Licensees are responsible for informing the Department of mailing address changes. Typically, about 10% of the license renewal forms are returned for insufficient address. This can result in delayed processing and lapse of the license. A license is considered lapsed 60 days following mailing of the application to the physician without response.

Physicians who elect inactive status can be excused from payment of renewal fees. Reactivation is permitted when fees are payed. During the inactive period the physician may not practice medicine.

A non-refundable fee of $300 is required for a three year license renewal. Non-residents renew at twice that amount. Restoration requires a $100 fee, plus lapsed fees (inactive licenses are not affected by this requirement.) The three-year temporary license fee for residency is $100. Additional surcharges apply to specific circumstances, such as duplicate licenses or change of address requests.

Residency Requirements

The subject of residency training received considerable scrutiny during the rewrite of the Medical Practice Act this year. Twelve months' postgraduate clinical training is required for those applying prior to January 1, 1988. After that date, more stringent-requirements will apply. These will include:

- 24 months' postgraduate training
- Of the minimal six year post-secondary course of study, at least two years' academic study in basic medical sciences with two additional years in the clinical sciences while enrolled in the medical college conferring the degree.
- For foreign medical school graduates, core rotations in clinical teaching facilities owned, operated or formally affiliated with the medical college conferring the degree. (Clinical externships during the third and fourth year of medical school at U.S. hospitals not controlled by the foreign medical school of graduation will not be accepted.)

  Graduates of medical or osteopathic colleges accredited by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools or the American Osteopathic Bureau on Professional Education are not limited to externships controlled by their school of graduation, but all other rules apply.
- Applicants who began, but did not complete, a foreign medical education may be permitted to complete an academic year of supervised clinical training under the direction of an accredited U.S. medical school in addition to the 24 months' clinical training.

ing individual compliance with those rules are not specifically assigned to the licensing board, but they are logically related to its function. Such rules are to be relevant to a person's practice and consideration is given licensees subject to equivalent requirements from a specialty society, a medical staff, or for continued board certification.

While the Act is generic, the rules will recognize various accredited CME programs, programs required by specialty boards, activities required by specialty societies, medical and teaching activities, and utilization of materials relevant to the individual's practice. The rules, as they did previously, will include a waiver for situations where CME opportunities are not readily available or where hardship exists, or where the absence of the physician from the community would create a void in the availability of care.

Finally, under the Physicians Assistants Practice Act, two members of the Licensing Board are assigned to the Physician's Assistants' Advisory Committee. Their responsibilities are generally advisory and supervisory.

The Medical Licensing Board provides a strong mechanism to keep professional standards high and reasonable. This overview is intended to provide a sense of the thinking behind the organization and work of the Board; more specific information on the conditions and procedures for licensure is included in the story on page 182 or may be obtained by contacting ISMS staff.

Lawrence L. Hirsch, M.D., a member of the Medical Licensing Board since 1982, is professor and chairman of the department of family medicine at the Chicago Medical School, North Chicago. Dr. Hirsch was a member of the Task Force on Medical Discipline, an ISMS-supported group which successfully sought major reforms in the Medical Practice Act. He is a past president of the Chicago Medical Society, a former member of the ISMS Board of Trustees and former speaker of the ISMS House of Delegates. Dr. Hirsch was a member of the ISMS Executive Committee when the Medical Practice Act was under legislative review.

EKG

(Continued from page 160)

Answers: 1. C, D 2. B, C, D

This twelve lead ECG shows a normal sinus rhythm with a normal PR interval of 0.16 seconds and a QRS duration of 0.08 seconds. The rate is 56 beats per minute. There is marked ST segment elevation in leads II, III, and AVF with reciprocal ST segment depression in leads V_1 to V_6. This is an acute inferior, true posterior current of injury, and is compatible with an acute inferior infarction. In the setting of an acute inferior myocardial infarction, reciprocal ST segment depression in the anterior leads has been associated with more extensive coronary disease.[1]

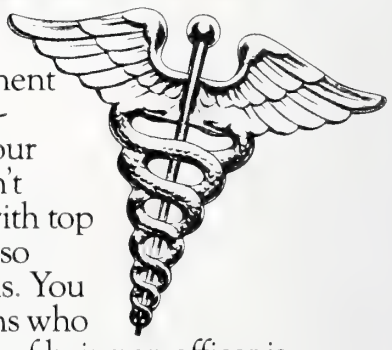
Intravenous thrombolysis with streptokinase would not be useful here because the patient presented much too late, more than four hours after the onset of the infarction pain. Intravenous nitroglycerin plus nifedipine were, in fact, used. However, the ST segment did not start to descend to the baseline with relief of chest pain until after the intraaortic balloon counter-pulsation was started. An emergency coronary angiogram demonstrated an occluded aorta coronary bypass graft to the left anterior descending artery. The right coronary vein graft was patent, but a 90% obstruction had developed in the right coronary artery distal to the anastomotic site of the graft. The left circumflex obtuse marginal had developed an 80% obstruction not present six years earlier. The patient's left ventricular end diastolic pressure was 30mmHg with a cardiac output of 4.3 liters/minute.

In the presence of impending infarction with much myocardium in jeopardy, repeat aorta coronary bypass surgery was performed. Postoperatively the patient needed the intraaortic balloon counterpulsation for three days. This was removed and he had an uneventful recovery thereafter.

Reference

1. Nasmith, J., *et al.*: "Clinical Outcomes After Inferior Myocardial Infarction," *ANN INT MED* 96:22-26, 1982.

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Responsibility and Authority

A Fresh Approach to Discipline

Recommendations emanating from the Governor's Task Force on Medical Discipline sought increased resources, expanded investigatory and disciplinary authority and clarified grounds for discipline. The new Illinois Medical Practice Act reinforces former provisions and incorporates new measures for this purpose.

Many new and amended sections of the 1987 Medical Practice Act originated from the Governor's Task Force on Medical Discipline, an ISMS-supported body which examined the effectiveness and efficiency of the state's disciplinary process. The Task Force identified and recommended action to remove obstacles for discipline of physicians violating state laws.

Increased Resources

The new Illinois Medical Practice Act increases the number of investigators and attorneys who can be assigned to cases involving MDs, osteopaths and chiropractors. It also provides for a second physician to serve as deputy medical coordinator for the Chicago office of the Illinois Department of Registration and Education. A single physician presently functions as medical coordinator for the Medical Disciplinary Board and the two Department offices in Springfield and Chicago.

Any license restrictions mandated by the disciplinary or licensing boards due to mental or physical condition are to be monitored by one of the medical coordinators. He or she may review the physician's compliance and the status of any treatment or counseling.

Under the new law, the Disciplinary Board can create a formal roster of physicians around the state to serve as expert consultants for the medical coordinators in screening and evaluating medical complaints and issues.

Finally, the Act now allows the state to contract with ISMS or other professional organizations to assist the Medical Disciplinary Board in conducting medical competency examinations and reviewing alleged violations of the Medical Practice Act.

Expanded Authority to Investigate and Discipline

Formerly, violations of the law were cause to revoke, suspend, reprimand or place a license on probation. Under the new law, the state may also fine physicians for violations where the physician's conduct did not result in the death or injury of a patient. The fine, not to exceed $5,000 for each violation, may be imposed in addition to other forms of discipline.

Under the 1987 Act, the Disciplinary Board can subpoena medical and hospital records of a physician's patients if it determines that a probable violation of the Act has or is occurring. All identifiers from the records are to be removed prior to their review by the Board. An investigation will no longer be derailed by the need to obtain a patient's consent for the release of specific records. Also, confidentiality of patient medical records will be preserved.

Another new section enables the Disciplinary Board to send an investigator to a physician's office to inspect the physical premises, equipment and furnishings when there is probable cause to believe that a violation of one or more of the grounds for discipline exists. These office inspections could verify or disprove allegations of unsanitary conditions or unlicensed personnel. Although the law permits inspection of an office, it specifically prohibits access to business, medical or personnel records on the premises. A subpoena is required to review such records.

An extended statute of limitations will now permit the state additional time to take action against a physician. Under the new law, the time clock runs from the point the state received a formal decision or complaint and not, as previously provided, from when the action took place. The Board has three years from when a report is

Grounds For Medical Discipline in Illinois

State authorities can revoke, suspend, place on probation, or otherwise discipline a physician's license on the following grounds:

1. Performance of elective abortion in an inappropriate locale, facility or institution, as defined in the Act.
2. Willful and wanton performance of an abortion on a woman not pregnant.
3. Conviction of a felony in Illinois or any other jurisdiction, whether or not related to medical practice.
4. Gross negligence in medical practice.
5. Dishonorable, unethical or unprofessional conduct likely to deceive, defraud or harm the public.
6. Obtaining any fee by fraud, deceit or misrepresentation.
7. Habitual or excessive alcohol or drug abuse resulting in the inability to practice with reasonable judgment, skill or safety.
8. Practicing under a false or assumed name.
9. Fraud or misrepresentation in applying for a medical license.
10. Making false or misleading statements on the skill, efficacy or value of medical treatments prescribed at the physician's own direction.
11. Allowing another person or organization to use a physician's license.
12. Disciplinary action by another state or jurisdiction.
13. Violation of any provision of the Medical Practice Act.
14. Commissions, rebates, fee-splitting or other form of compensation for services not actually and personally rendered.
15. Failure to comply with the terms of probation by the Medical Disciplinary Board.
16. Abandonment of a patient.
17. Prescribing, selling, administering, or distributing controlled substances for non-therapeutic purposes.
18. Exploiting the patient for financial gain by promoting sale of drugs, devices, appliances, or goods.
19. Offering to cure or treat diseases by any secret method which the physician refuses to divulge to licensing authorities.
20. Immoral conduct in the practice of medicine.
21. Willfully making or filing false records to support public aid or other claims.
22. Purposely not filing, or willfully failing to report an incident of suspected abuse or neglect.
23. Causing a child to be abused or neglected.
24. Solicitation of professional patronage.
25. Gross, willful and continued overcharging of patients and filing false statements for services not rendered.
26. A pattern of practice which demonstrates incapacity or incompetence.
27. Mental illness or disability which results in the inability to practice with reasonable judgment, skill or safety.
28. Physical incapacitating illness resulting in inability to practice with reasonable judgment, skill or safety.
29. Cheating on a licensing exam.
30. Willful or negligent violation of physician-patient confidentiality except as required by law.
31. Using false, fraudulent or deceptive statements in any document connected with medical practice.
32. Aiding or abetting the unlicensed practice of medicine.
33. Violating state or federal controlled substance laws.
34. Failing to report to state licensure authorities any adverse final action taken by another state or jurisdiction's licensing agency.
35. Failure to report to state licensing authorities the surrender of a license or authorization to practice.
36. Failure to report to state licensing authorities any adverse liability judgment, settlement or award arising from conduct constituting grounds for discipline.
37. Failure to transfer copies of medical records.
38. Failure to furnish state licensure authorities with legally-requested information. ◂

five years from the date of the incident, to act.

New and Amended Grounds for Discipline

The 1987 Act clarified several of the disciplinary grounds to make it easier for physicians to know when they violate the law and to help the state prosecute certain types of cases. A few of the more important changes are described below:

- Convictions for felonies have always been cause for discipline, but the crime need no longer be related to the practice of medicine in order for the state to act.
- It is no longer necessary that a malpractice incident result in the death or injury of a patient before the state can file charges. The provision has been changed to require only that there was "gross negligence."
- Violations for fraud and misrepresentation have been clarified.
- The state can now discipline a physician who has been disciplined by another state in ways other than by revocation and suspension of license.
- The law now clearly provides that a physician who personally uses controlled substances for other than medically accepted purposes can be disciplined.
- Physicians can be disciplined for failing to submit required reports to the state. A provision that made it a crime for a physician to fail to report child abuse has been clarified.

The disciplinary grounds have also been expanded to include new provisions. Many deal with business or practice management decisions which may not impact patient care. Others cover issues in the physician-patient relationship.

New causes for action include cheating on the licensing examination, breaching confidentiality, using false statements, helping unlicensed persons practice medicine, violating controlled substance laws, failing to give the state information as legally requested and failing to transfer records as required by law-(since 1985, the law has required that a physician transfer a patient's records to a designated physician or attorney within 60 days of receiving a written request from the patient. This was part of the medical malpractice package of reforms.)

Other new provisions hold the physician responsible for reporting actions taken against him or her by other entities. This is the other side of mandatory reporting. The law now requires that the state receive a report of an action not only from the facility or organization disciplining a physician but also by the physician who was the subject of the discipline action.

Physicians must now report when another state has taken action against their licenses, as well as actions by hospitals, professional societies, governmental bodies and law enforcement agencies. The physician must report whenever he or she surrenders a license or membership on a medical staff or professional organization due to disciplinary proceedings. Finally, malpractice judgments or settlements are reportable.

Protections Increased

The law retains protections for individuals who participate in or submit information to peer review bodies and provides new protections for organizations that assist state investigations. While physicians are not required to report a colleague, the new law does encourage reports of violations of the Act, and provides protections for those who do so in good faith.

Hospital Credentialing

The bill which created the 1987 Medical Practice Act also amended the Hospital Licensing Act. A hospital must now contact the Department of Registration and Education to determine licensure and disciplinary status prior to appointing or re-appointing a physician to its medical staff. If the state has information about a physician being monitored for an impairment, those facts must also be forwarded to the inquiring hospital.

Summary

The new Act gives the Department and the Medical Disciplinary Board many more tools to identify, investigate and prosecute physicians who allegedly have violated the law. It also provides opportunities and protections for organized medicine and individual physicians to participate in this process to assure fair, objective and medically-based decisions. Many new regulations will be needed to implement these provisions. Most important, time will tell if the law works as written or if additional amendments are needed. ◂

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A National Perspective

The Physician Disciplinary Data Bank

By Dale G Breaden,
Associate Executive Vice President,
Federation of State Medical Boards

The recognized national depository for disciplinary information about physicians in the United States is the Physician Disciplinary Data Bank (DDB) of the Federation of State Medical Boards of the United States. The DDB is designed to meet the Federation's obligations to its 65-member physician licensing and disciplinary boards and the public they serve. It functions in the context of the Federation's overall role in relation to medical discipline.

The Federation and its member boards seek first to protect the public from unqualified, unfit, and impaired physicians. For this reason, they work to identify those physicians through the systematic review of meaningful markers and indicators of performance and fitness, to act against them in accord with due process of law, and to prevent their undetected movement from one jurisdiction to another. This formidable task must be pursued diligently and should not interfere needlessly with the practice of medicine by the overwhelming majority of fine physicians.

The need to identify possibly unfit, unqualified, or impaired physicians is fundamental to the work of the boards, and the task cannot be done in an information vacuum. The so-called conspiracy of silence among physicians is dying away in the face of today's realities. There is really no choice. The unfit practitioner must be weeded out to protect the profession as well as the public.

Mandatory Reporting

To answer the need for information identifying possible problem physicians, many states have enacted legislation requiring reports to the boards by certain persons, institutions, and organizations. Although these compulsory reporting laws vary from state to state, they usually pertain to health care facilities, liability insurance carriers, and individual licensees. They may also require reports from courts, law enforcement agencies, and medical societies. With the exception of individual licensees required to report apparent violations by colleagues, reporting laws usually involve informing the medical boards of specific formal disciplinary or legal actions. However, when a physician withdraws from a medical staff while under review for disciplinary reasons, that fact may also have to be reported, as it should be.

The Federation actively encourages these laws. Its "Guide to the Essentials of a Modern Medical Practice Act," states this position clearly. This is not to deny the value of complaints received from the public. Such complaints are vital and can lead to significant action. Often, however, they involve issues that do not reflect upon a licensee's fitness for practice. To improve and encourage this source of information, the Federation has developed and distributed a "Model for the Preparation of a Guidebook on Medical Discipline." The boards can use this publication, among other things, to assist the public in understanding the role and disciplinary function of the state medical boards, increasing the quality of public reporting and reducing meaningless complaints. But medical boards cannot function as effectively as they must without the information provided through enforceable compulsory reporting laws.

Essential to mandatory reporting is protection for those who report. When acting in good faith, they must be assured immunity at both

state and federal levels. Similar protection must extend to medical board members, staffs, committees and to all those engaged or assisting in legitimate professional peer review. Equally important, however, is the legal protection of the accused physician, who must be assured of due process and must be shielded from harassment.

Reregistration

Many medical boards are adopting more effective license reregistration rules that require the filing of forms on which licensees report any sanctions taken against them during the reregistration period, usually one or two years. The number of states in which physicians could simply mail a check to reregister their licenses is decreasing noticeably, as it should be. In the early 1980s, the Federation's Ad Hoc Committee on Physician Evaluation for Reregistration proposed a more effective reregistration system and took the lead in urging boards to recognize that reregistration represents a time when licensees should be assessed in a systematic way. The Federation expects reregistration procedures to become more significant over the next few years. At the same time, it firmly rejects any suggestion that physicians should be required to pass a formal reregistration or relicensure examination to continue practice.

Markers and Indicators

A system reviewing currently available markers and indicators of possible performance or fitness problems (such as disciplinary actions by other states, adverse privileging actions by hospitals, other sanctions springing from peer review processes, malpractice judgments, settlements and awards, etc.) made available through enforceable mandatory reporting laws and other sources such as the Federation's Physician Disciplinary Data Bank, combined with self-reporting on reregistration forms, can provide a coherent approach to identifying possible problem physicians. This system reveals significant events or, more likely, patterns of events indicating questionable performance or fitness. Once identified, physicians who present concerns to the medical boards can be more precisely evaluated through appropriate means: informal interviews, physical and/or mental examinations, cognitive and/or skills examinations, investigations, etc. In the Federation's view, if the medical boards are properly funded to implement the markers and indicators system, and if enforceable mandatory reporting is universally adopted, effort will be concentrated where it belongs—on those who have demonstrated inadequate professional ability or fitness.

Endorsement Examination

The Federation is also urging that medical boards require written clinical examinations for those physicians who seek licensure by endorsement and who are eight to ten years away from any other testing approved by the medical boards. Some states now have this policy and the Federation hopes all will adopt it to assure that physicians who leave their established practice and peer review environments to enter new jurisdictions have maintained their qualifications over time.

The Physician Disciplinary Data Bank

The improved systems being advocated by the Federation provide the markers and indicators required to identify possible problem physicians, for a report or a series of reports is only the beginning of a review conducted in the context of law. With this background, it should be clear that the computerized Physician Disciplinary Data Bank—the DDB—is an essential function of the Federation's role in relation to effective medical discipline, a role deeply rooted in the Federation's history and experience. Since 1915, the Federation has collected and disseminated information on formal disciplinary actions taken by its member medical boards against licensed physicians and applicants for licensure. For many years, however, reporting by the boards was inconsistent and uneven. In the early 1970s, the monthly "Disciplinary Action Report" was created, improving communication among the various state boards, and throughout the decade, the level and quality of reporting by the medical boards steadily improved. More began to use the "Disciplinary Action Report" as a resource to identify their licensees disciplined in other jurisdictions. Meanwhile, a formal recording system was developed by the Federation, establishing a permanent card file of disciplinary actions as a continuing reference source for all medical boards.

With the advent of cost-effective small computers offering large capacity and high speed, the Federation began planning the computerization of its rapidly growing disciplinary data base in the early 1980s. The process was begun using microcomputers. In late 1984, a state-of-the-art computer using the Unix operating system was installed, bringing what by then was called the Physician Disciplinary Data Bank (DDB) to a high level of sophistication. By that time, with rare exception, all medical boards were reporting their formal disciplinary actions to the Federation and using the DDB to review applicants for licensure. Today, member medical boards have become active contributors to and users of the DDB, and its effectiveness is being clearly demonstrated as the Federation responds to requests for disciplinary data from medical boards and other agencies.

The DDB collects and stores disciplinary actions taken against physicians resulting from formal charges. The information is reviewed and categorized before being distributed monthly to all U.S. and territorial medical boards, to Canadian provincial licensing authorities (all of which are affiliate members of the Federation), to the American Medical Association for use in its Physician Masterfile Data Base, to the American Osteopathic Association, the DEA's domestic regional offices, the Department of Defense, the Department of Health and Human Services, and others. The report contains information vital to licensing and disciplinary boards in making responsible licensing decisions. It also permits the review of the disciplinary status of a state's licentiates in other jurisdictions. The DDB has been responsible for dramatically reducing the

The AMA Physician Profile Service: Another Information Source

The new Illinois Medical Practice Act requires that hospitals and medical staffs seek information on previous disciplinary actions against physicians applying or reapplying for medical staff privileges. The Act specifies that the Illinois Department of Registration and Education (to be called the Illinois Department of Professional Regulation after January 1) must be contacted for that purpose.

Additional information of value to credentialing efforts is available from the Physician Profile Service maintained by the American Medical Association. Information in the profile can be used to verify credentials and investigate the possibility of past licensure actions.

Hospital medical staffs can access the AMA physician profile to screen medical staff applicants. County medical societies may also want to use the profile service to credential new applicants.

Within two weeks of receipt of a properly-completed data request form, the AMA will forward a computerized printout including:

- Name of the physician
- Address
- Birth place
- Birth date
- AMA membership
- Medical education (school and year of graduation)
- State licensure (year and state of license)
- National board certification
- Specialty board certification
- Physician's professional activity
- Specialty (primary, secondary, and tertiary)
- Residency training (current and prior—Includes hospital name, dates of training, and specialty)
- Government service (current and prior)

If a state licensing board has taken disciplinary action against the physician, a letter so stating will accompany the response, listing the appropriate state board to contact for further information.

Information packets and data request forms can be obtained by contacting: Ms. Diane Mead, Department of Data Release Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610; (312) 645-5145.

As noted in the accompanying article, the AMA House of Delegates has voted to seek designation as private sector coordinator of the Practitioner Adverse Credentialing Data Bank required by the Health Care Quality Improvement Act of 1986. If the Government accepts the proposal, the AMA and the Federation of State Medical Boards will act as partners in collecting and providing information required by law to authorized entities. The Federation would continue its work, compiling information on actions taken by state licensure boards and federal sanctions. The AMA would collect and maintain information regarding reduction and loss of clinical privileges for over 30 days, professional liability indemnity payments and professional society membership losses. The AMA would disseminate all information, turning to the Federation for disciplinary action data when appropriate. ◀

movement of problem physicians from one jurisdiction to another undetected—a major accomplishment.

Clearly, actions ultimately reported to the Federation do not begin to reflect the full extent of the medical board effort. The disciplinary impact of the medical boards cannot be measured by the number of formal disciplinary actions they take. Most boards will deal informally with five to ten licensees for every such action. More often than not, these contacts are sufficient to significantly affect the behavior and/or performance of the licensees involved and to prevent the development of more serious problems calling for formal action. Beyond this, the process of identifying those physicians actually requiring formal or informal attention by a medical board often demands the careful review and closure of hundreds of cases or complaints—a difficult and time-consuming task.

The Federation's DDB has rapidly become a basic working tool for the physician licensing and disciplinary boards of this country. No formal disciplinary action can be considered complete until reported to the DDB; no application for licensure can be considered fully evaluated until screened through the DDB; and no disciplinary system can be considered effective until it includes regular review of the monthly DDB report. All of this, however, is possible only because the boards themselves have cooperated to make the DDB a reality.

The Federation's DDB has also been used over the past year and a half to screen all physicians in the military services, the National Guard, the military reserves, the Veterans Administration, and the Public Health Service. This task was facilitated by the use of nine-track tapes prepared according to Federation direction. The DDB is used as

a recruitment or hiring screen by those same organizations. At the same time, the armed forces, the Department of Health and Human Services, the Educational Commission for Foreign Medical Graduates, and the U.S. Postal Service report disciplinary actions and other sanctions to the DDB. The VA is also authorized to report sanctions to the Federation. Over one hundred hospitals use the DDB as a screen for hiring or privileging, as well. These wide ranging DDB services, available to those agencies or bodies needing such information in fulfillment of their lawful functions, are conducted under formal contract for an appropriate fee. Full legal responsibility for use of the data is specifically assumed by the entities contracting to receive them.

What the DDB provides is a triggering mechanism, an alert system that indicates an adverse report, based on legally accessible information that has been made to the Federation concerning a particular physician. While the Federation has documentation supporting the report, that documentation is not provided to the inquiring user. The DDB describes the nature and source of the report and specifically directs the user to the original reporting jurisdiction for verification and detail. No user is to make a judgment based on a DDB report alone. To do so would be irresponsible and a violation of the DDB contract. For this and other reasons, DDB reports are to be held in confidence by the users.

Federal Legislation: Title IV, PL 99-660

In view of the foregoing, it should be clear that thoughtful federal legislation promising to assist the state boards in their disciplinary tasks is welcome. Last year, when HR 5110 (later HR 5540) the Health Care Quality Improvement Act of 1986, was introduced by representatives Wyden, Waxman, and others, the Federation testified in favor of the legislation and worked as closely as possible with congressional staff as the bill went forward. The Federation understood the legislation was not ideal, and that, badly handled, it could be as much hindrance as help. But the bill addressed vital issues, and, fortunately, reflected many positions advocated by the Federation.

The legislation finally passed as Title IV of Public Law 99-660. While still not ideal, it is the law and must be protected from regulation writers who are often tempted to push beyond legislative intent. Among other things, Title IV extends immunity protection to those participating in professional peer review activity, if that activity is conducted in accord with specified due process procedures, and requires the reporting of malpractice and hospital privileging data to state medical boards. It also requires the Secretary of DHHS to establish or designate a national repository of adverse malpractice, disciplinary and hospital privileging data, to which professional liability insurers, state medical boards, and health care institutions must report. In turn, health care institutions wishing to benefit from the protections of Title IV are to screen the members of their medical staffs through the national data base when privileges are requested or renewed. Screening of each staff member is to be done at least once every two years. Clearly, the use of the data in the repository by health care institutions will require great care. This will be particularly true in the case of malpractice data, the value of which is open to serious question.

In supporting PL 99-660, the Federation strongly advocated immunity protection for professional peer review and mandatory reporting of malpractice and hospital privileging information to state medical boards. It urged, however, that implementation of a national data repository under the Secretary of DHHS be postponed until the other elements of the law had had a chance to affect the system. Having extensive experience in the area of disciplinary data collection and national screening programs, the Federation believed more detailed study of the repository envisioned by the statute was clearly needed. Such was not the will of Congress, however. The repository is to be established and functional by late 1987 under a contract to be awarded by the Health Resources and Services Administration. That being the case, the Federation's Board of Directors and membership and the AMA's House of Delegates have approved a partnership between the Federation of State Medical Boards and the American Medical Association for the sole and specific purpose of presenting a bid for joint operation of the data repository called for in Title IV. Under the partnership arrangement, the Federation would operate and fully control the disciplinary component of the repository. The Federation's DDB would continue to function as it does now. The AMA would develop and operate the malpractice and hospital privileging components of the repository.

Conclusion

Meanwhile, the Federation is going forward with further development of the DDB. As an example, plans are now being made to permit state medical boards to receive an initial response (yes, no, or possible) to a disciplinary inquiry through a direct on-line computer system. That system would be fully secure and would not involve a direct connection to the DDB itself.

Such a system would be a logical expression of the Federation's determination to see that the disciplinary information program begun in 1915 and arduously shaped over the intervening years continues to improve in efficiency and responsiveness. That program was conceived, established, and perfected by the Federation. It represents a unique contribution to the protection of the American people and to the integrity of the medical profession. It functions now and it functions well and will continue with or without the elaboration of Title IV, simply because it is necessary and because the Federation does not intend it to be anything less than it can be. ◀

Dale G Breaden is associate executive vice president of the Federation of State Medical Boards of the United States. Among his other duties, he edits two triennial publications for the Federation, "A Guide to the Essentials of a Modern Medical Practice Act," and "A Model for the Preparation of a Guidebook on Medical Discipline."

OBITUARIES

***Baldoza, Maximo B.,** Hinsdale, died April 3, 1987 at the age of 54. Dr. Baldoza was a 1957 graduate of the Faculty of Medicine and Surgery, University of Santo Tomas, Manila, Philippines.

****Chobot, Jerry S.,** Riverside, died July 28, 1987 at the age of 84. Dr. Chobot was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

****O'Connell, Morgan J.,** Lauderdale-by-the-Sea, Florida (formerly of Chicago), died July 29, 1987 at the age of 88. Dr. O'Connell was a 1923 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Steck, Irving E.,** Pompano Beach, Florida (formerly of Skokie), died July 10, 1987 at the age of 83. Dr. Steck was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

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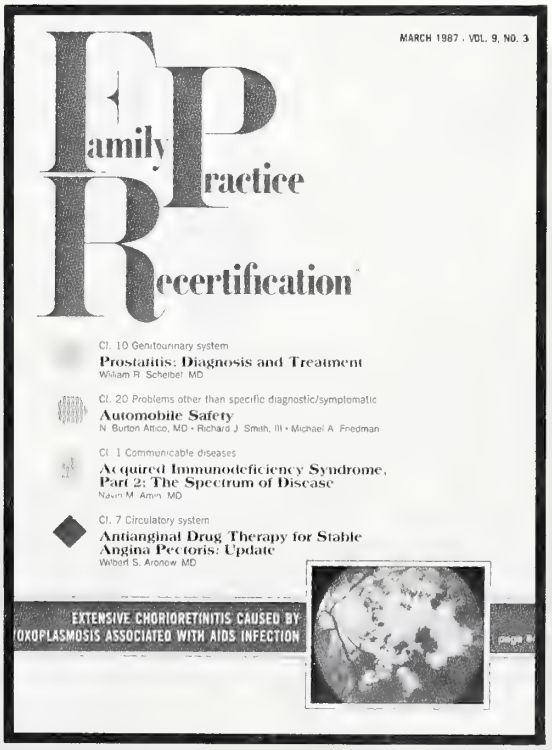
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Growing Through Goals

By Cheryl Hutchison, CMA/Granite City

"Growing with Illinois Society Medical Assistants" is the theme for the 1987-1988 year and membership is our number one goal. Several different surveys will be mailed to members in the near future asking such questions as why certified medical assistants may not join the Illinois Society of Medical Assistants, why members do not rejoin, and what our membership would like our organization to accomplish.

The use of education to help our organization grow is another of our goals. Several excellent educational programs are being developed throughout the state on such topics as malpractice and Medicare updates.

Professional recognition is another of our goals. To attain this we will be promoting ISMA among physicians through the *Illinois Medical Journal* and by speaking to local medical societies on the benefits of hiring medical assistants and certified medical assistants. We will also try to increase public recognition of the role of medical assistants by submitting articles to local papers and publications.

Finally, communication is another important goal we hope to achieve this year, keeping the lines of communication open from the local level to the national level. The importance of timeliness in all communication will be stressed to everyone.

All of the above goals cannot be reached by one person, or even by just a few—it will take the entire membership to help us achieve them.

Further information regarding the Illinois Society and/or medical assisting can be obtained by contacting Cheryl Hutchison, CMA, ISMA president, 53 Lockhaven, Granite City 62040, or the public relations co-chairpersons, Lesa B. Hildebrand, Ed.M., CMA-C, Triton College, 2000 Fifth Avenue, River Grove 60171, or Lucille Perce, CMA-C, 22W384 Teakwood, Glen Ellyn 60137.

A reminder: The National Annual Business Meeting will be held October 16-18 at the Holiday Inn Mart Plaza, Chicago. ◀

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

October

Cardiology

Cardiomyopathy and Congestive Heart Failure
For: Cardiologists, Lecture, October 27, Kishwaukee Community Hospital, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K. P. Reddy, M.D. **Phone:** (815) 756-1521 × 3486.

Critical Care Medicine
Sixth Annual Chicago Critical Care Symposium
For: Physicians, Physicians-in-Training, and Nurses. Lectures, panel discussions, October 15-18, Chicago Downtown Marriott Hotel. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** $390 Physicians/$245 Physician-in-Training, Nurses, Health Specialists. **Reg. Limit:** None. **Reg. Deadline:** October 15. **Credit:** Category 1: 24.5 hours; and AAFP Prescribed. **Contact:** Ben Blivaiss, Ph.D. **Phone:** (312) 578-3215.

Controversies in Antiviral Chemotherapy
For: Oncologists. Course, October 31, 8:00 a.m.-3:30 p.m., Oak Brook. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Chicago, IL 60637. **Fee:** $25. **Reg. Limit:** None. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Internal Medicine

Specialty Review in Gastroenterology
For: Internists and Gastroenterologists, Lecture, October 5-9, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** None. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Neurology

Current Clinical Neurology: A Comprehensive Review
For: Neurologists, Psychiatrists & Neurosurgeons, Lecture, October 12-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $570. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Obstetrics and Gynecology

Specialty Review in Obstetrics and Gynecology: Practical Aspects
For: Obstetricians, Gynecologists, Lecture, October 4-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $715. **Reg. Limit:** 90. **Credit:** Category 1: 55 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Ophthalmology

Laser Treatment of Common Fundus Diseases—Why, When & How
For: Ophthalmologists. Workshop, October 9-10, Concourse Hotel, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME, 465A WARF Building, 610 Walnut St., Madison, WI 53705. **Fee:** To Be Announced. **Reg. Limit:** 90 **Credit:** Category 1: 10 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Pathology

Seminar on AIDS, Part I (HIV Viral Studies and Pathology)
For: Pathologists. Lecture, October 12, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, Michael Reese Hospital, Loretto Hospital. **Fee:** None. **Reg. Limit:** None. **Credit:** Cateogry 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 6264300, Ext. 5720.

Advances in Anatomic and Clinical Pathology
For: Pathologists. Lecture, October 19-24, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $630. **Reg. Limit:** 90. **Credit:** Category 1: 51 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Pediatrics

Seminars in Pediatrics
For: Physicians and other health professionals. Conference, October 23-24, U.W. Hospital, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME, 465A WARF Building, 610 Walnut St., Madison, WI 53705. **Fee:** To Be Announced. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AAFP Prescribed. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Origins of Fetal Brain Injury Prior to Labor
For: Obstetricians, Pediatricians, Family Practitioners. Conference, October 21, 1987. **Sponsor:** The University of Illinois College of Medicine, 1 Illini Drive, Peoria, IL **Fee:** $55. **Reg. Limit:** 150. **Credit:** Category 1: 6.0 hours. **Contact:** Tim C. Miller, M.D. **Phone:** (309) 655-2136.

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, October 23-25, Holiday Inn Mart Plaza, Chicago. **Sponsor:** University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** 175. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Psychology of the Self: The Next Decade
For: Psychiatrists, Psychologists, Nurses, Social Workers. Lecture/Workshop, October 23-25. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago. **Fee:** $225. **Reg. Limit:** None. **Credit:** Category 1: 16.5 hours. **Contact:** Office of Continuing Medical Education. **Phone:** 942-7095.

Radiology

Magnetic Resonance Imaging
For: Physicians, Lecture, October 6, Kishwaukee Community Hospital, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K.P. Reddy, M.D. **Phone:** (815) 756-1521 x 3486.

Surgery

Specialty Review in Pediatric Surgery
For: Surgeons. Lecture, October 5-9, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $575. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Specialty Review in General Surgery, Part II
For: General and Specializing Surgeons, Lecture, October 19-30, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 103 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Arthroscopy
For: Physicians, Lecture, October 20, Kishwaukee Community Hospital, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K.P. Reddy, M.D. **Phone:** (815) 756-1521 x 3486.

November

General

Teaching Stress Management and Relaxation Skills
For: Physicians, Nurses, Health Professionals. Workshop, November 9-13, La Crosse, WI. **Sponsor:** University of Wisconsin-La Crosse, Wisconsin Heart Institute, La Crosse, WI. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours. **Contact:** Philip K. Wilson. **Phone:** (608) 785-8686.

Newer Antithrombotic Drugs—Newer Strategies in the Management of Thrombotic Disorders
For: Neurosurgeons, Cardiologists, Surgeons, Hematologists, Oncologists. Symposium, November 12-14, Oakbrook Hyatt, Oakbrook. **Sponsor:** Loyola University of Chicago, Stritch School of Medicine, 2160 South First Avenue, Maywood, IL 60153. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 23 hours. **Contact:** Jaweed Fareed, Ph.D. **Phone:** (312) 531-3236.

Pulmonary Disease

Weekend Refresher in Pulmonary Diseases
For: Primary Care Physicians. Lecture, Case Studies, Q&A, November 13-14, Eagle Ridge Inn & Resort, Galena, IL. **Sponsor:** University of Illinois College of Medicine at Chicago, 912 South Wood St., 2 North, Chicago, IL 60612. **Fee:** $180. **Reg. Limit:** 120. **Credit:** Category 1: 10 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-8025.

Primary Care

Diagnosis & Pitfalls of Common Hand Injuries
For: Physicians who treat acute hand trauma. Course, November 21, Chicago. **Sponsor:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, CO 80014. **Fee:** $125/$75. **Reg. Limit:** 250. **Credit:** Category 1: 7 hours. **Contact:** Anne Turner. **Phone:** (303) 755-4588.

Neurology

Clinical Neuroimmunology V
For: Neurologists. Symposium, November 5-8, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Pathology

Seminar on AIDS, Part II—(Laboratory Diagnosis & Personnel Precautions)
For: Pathologists, Lecture, November 9, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, Michael Reese Hospital, Loretto Hospital. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Psychiatry

Multiple Personality/Dissociative States
For: Psychiatrists, Psychologists, Nurses, Social Workers. Lecture/Workshop, November 5-7. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 25 hours. **Contact:** American Society of Clinical Hypnosis. **Phone:** (312) 942-7095.

December

Cardiology

Advances in Aortic and Mitral Stenosis.
For: Cardiologists. Course, December 11-12, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago. **Fee:** TBD **Reg. Limit:** None. **Credit:** Category 1: TBD. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

General Medicine

Symposium on the Prevention and Treatment of Pressure Ulcers.
For: Family practitioners, dermatologists, geriatrics. Symposium, December 12-13, Oakbrook, IL. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Chicago, IL 60637. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1: TBD. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Neurology

Neurology for the Non-Neurologist.
For: Family Practitioners, Internists, Psychiatrists. Lecture/Workshop, December 9-11. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago. **Fee:** $400. **Reg. Limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Office of Continuing Education. **Phone:** (312) 942-7095.

Obstetrics and Gynecology

Problem Solving in Gynecologic Endocrinology & Infertility
For: Obstetricians, Gynecologists. Course, December 11-12, The Knickerbocker Hotel, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Chicago, IL 60637. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

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(continued from page 144)

Diagnosis: Duplicated collecting system with atrophic lower pole moiety.

There are fewer calyces of the right kidney compared to the left (Figure 1) and the oblique view shows opacification of a deformed calyx in the protuberant mass of the lower pole (Figure 2). These findings make a duplex kidney the best choice. Delayed film confirms the diagnosis by showing the two ureters. (Figure 3) The lower pole of the duplex kidney is atrophic and has the appearance of a mass protruding from the kidney. A lobar infarct could deform the lower pole, but the underlying calyx would be normal following infarction. A renal neoplasm could protrude from the surface of the kidney and deform a calyx, but would not account for the decreased total number of calyces in the kidney.



Figure 3
Delayed film of right kidney shows duplicated renal pelvis with ureter to upper pole (curved arrows) and ureter (straight arrow) to atrophic lower pole.

Duplex Kidney

Duplication of the renal collecting system, either partial or complete, is the most common congenital renal anomaly, with an incidence of 0.3%-6%.[1,2] Duplications range in extent from a bifid renal pelvis to complete ureteral duplication with separate orifices in the bladder or one ureter with an ectopic location outside the bladder.[2] Complications of the duplex kidney (duplicated collecting system) are varied, usually relating to obstruction, incontinence or infection.[3] Occasionally duplication results in a pseudotumor which must be differentiated from a neoplasm.[4]

Embryology

A background of the embryologic development of the kidney and collecting system is essential to understanding duplex kidneys and their potential complications. The development of the urogenital system begins in the third week in the intermediate mesoderm cell layer.[5] Three different overlapping kidney systems develop from this cell layer during intrauterine life, including the pronephros, mesonephros and metanephros systems, although only the metanephros persists at birth.[6]

The metanephros develops in the pelvis and later migrates to a more cranial position as the body grows in the sacral and lumbar regions and the fetal curvature is diminished. The excretory units develop from the metanephric blastema and the collecting system is formed from the ureteric bud.[5] In normal development, the ureter is formed from a bud arising from the dorsal surface of the lower end of the wolffian duct. Later in development the ureter is incorporated into the bladder laterally and the lower wolffian duct migrates medially, eventually forming the vas deferens, seminal vesicles and ejaculatory duct in the male, and vestigial structures in the female.[1] The ureteral bud penetrates the metanephric blastema forming the primitive pelvis, which subsequently divides and subdivides resulting in the development of the major and minor calyces and approximately three million collecting tubules.[5] The presence of the ureteral bud stimulates the formation of nephrons in the metanephric blastema, resulting in mature renal parenchyma.

Anomalies in development resulting in duplication may occur at any time from the formation of the ureteral bud until its union with the metanephric blastema. Renal duplication is thought to be genetic, inherited as an autosomal dominant characteristic with incomplete penetrance.[7]

Complete duplication occurs when two ureteral buds develop from a single wolffian duct.[1] The inferior bud joins the metanephric blastema in an inferior location and has a normal lateral insertion in the bladder. The superior bud joins with the superior aspect of the

metanephric blastema, but as the wolffian duct migrates medially, this upper segment is carried along, resulting in an ectopic insertion into the bladder, ureter, vagina or epididymal region. In males this ectopic ureteral orifice lies above the external sphincter and does not cause incontinence, but in females it characteristically lies below the sphincter in the perineum or vagina, resulting in incontinence.[7]

Partial duplication results from abnormally early branching of a ureteral bud occurring at any level from the bladder wall to the renal pelvis.[8] In rare cases, a branch of a bifid ureter ends blindly as a diverticulum, which may be responsible for recurrent urinary tract infections.[9]

Complications

Both obstruction and reflux may complicate duplex kidneys. The upper pole moiety is susceptible to obstruction by aberrant arteries crossing its ureteropelvic junction or from its ectopic insertion.[4] Seventy percent of all extravesical ectopic ureters are associated with complete duplication and always involve the upper moiety.[10] The most frequent sites of insertion in the male are the prostatic ureter and seminal vesicles, while in the female the urethra and perineum are most frequently involved.[1]

The most common cause of acquired disease in the duplex kidney is vesico-ureteric reflux, usually involving the lower pole moiety. This results from an abnormal uretero-vesical junction, as the ureter courses straighter and more directly through the bladder wall. Reflux may also lead to recurrent infection and obstructive atrophy.[11]

Pseudotumors

The duplex kidney is the source of three types of pseudotumors. The most common is a large column of normal cortical tissue, a column of Bertin. Next in frequency is an obstructed upper pole moiety which usually presents as a pseudotumor in children but also is found in adults. The least common is a pseudotumor produced by an atrophic lower pole moiety as seen in the patient presented here.

Renal cortical pseudotumors (cloison or Bertin) are usually found in association with partial or complete pelvocalyceal duplications, and should not be mistaken for neoplasms. They are usually found between the upper and interpolar portions of the kidney and consist of an unusually large volume of normal septal cortex tissue that has persisted following lobar fusion. Radionuclide imaging, sonography, computed tomography, and angiography will all show that this pseudotumor is actually normal renal tissue, should there be a problem in diagnosis on excretory urograms.[4]

Obstruction of the ureter emptying the upper moiety of a duplex kidney may result in dilation of its collecting system and finally nonfunction. When the collecting system is not opacified on an excretory urogram, the upper pole has the appearance of a renal mass and may be mistaken for a neoplasm. A decreased number of opacified calyces in the kidney along with depression of the collecting system of the lower pole (drooping lily sign) are clues indicating that the upper pole mass is actually the obstructed upper moiety of a duplex kidney. If the unopacified ureter to the upper pole is markedly dilated, it will displace the opacified lower pole ureter, thus producing another clue to the correct diagnosis.

The patient presented here shows marked parenchymal deficiency in the lower half of a duplex kidney. The atrophic lower pole has the appearance of a renal mass extending from the inferior pole of the kidney. The paucity of calyces in the kidney and a flattened appearance of the lower pole are clues indicating that this is actually the atrophic lower half of a duplex system. In most patients, as in the patient presented here, visualization of a portion of the collecting system in the pseudotumor will confirm the presence of a duplex kidney and avoid unneeded further diagnostic studies.[3] ◀

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

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PRESIDENT'S PAGE

How to Get Ahead in Medicine

"Invent a Pessary"



Dr. Elias Wenger, president of the ISMS, in his 1887 annual address before the doctors of Illinois said, among other things, "We are an excitable people in our zeal and enthusiasm in trying to excel in doing good. We sometimes too readily adopt new ideas, try new remedies and new inventions, so highly recommended by their discoverers or inventors. My advice is to go slow in adopting new remedies and new inventions, as their authors generally know a great deal more about the pecuniary profits of the discovery than they do about the therapeutic value of the article. You all know what a craze invaded our ranks a few years ago. Many of our over zealous and enthusiastic brethren seemed to think that the surest and quickest way to reach the top-most round in the professional ladder would be to invent a pessary, and such a display of rings, oblongs, circles, semi-circles, curves, twists, turns, contortions and wind bags was never witnessed before."

Here we are a hundred years later continuing the technological race. We have other things in the medical dust bin besides pessaries. Remember gastric freezing machines, carotid body denervation for asthma and carbon dioxide inhalation therapy?

Physicians working in clinical and basic research have improved the quality and length of life over these last one hundred years, but so have modern sanitation, sewers, clean water and elementary hygiene. Technological wizardry and clinical expertise are important advances, but there is an additional modern breakthrough that ranks with the above-mentioned.

Civilization as we know it rests on paper work, bureaucracy, communications, committees, departmental structures, executives, librarians and the continual exchange of information among people. This issue of the *Journal* is sometimes criticized as being boring, but think about it. I challenge you to leaf through this issue page by page for the next 15 minutes. Put yourself in any of the activities listed and judge them with a professional eye.

I would suggest that the hours of meetings, resolutions passed, policies enacted and the council and committee activities described are a manifestation of civilized behavior equal to any technical discovery or public health accomplishment.

No headlines will be garnered if you go to your county society and ask your trustee to offer your name to serve in our Society's work. Your contribution will be as valuable to the advancement of patient care as more visible medical accomplishments. We know medicine, patient care and healing, and we know best the environment in which it must be delivered. So we have an obligation to run it or to tell the people who do how to do it best (whether they listen or not).

So, if you want to get ahead, to make your mark in your remaining years in this profession, I ask you to consider service as shown in the pages of this issue of the *Journal.* While this activity is not as eye-catching as a new pessary, it will give you satisfaction to know you have served in a unique way to advance medical care. ◀

Edward J. Fesco, M.D.

Edward J. Fesco, M.D.
President

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient was a seventy-six year old man who had coronary artery disease. Two years earlier, he had had an inferior wall myocardial infarction. A coronary angiogram taken at that time showed a totally occluded right coronary artery and a sixty percent obstruction of the left anterior descending artery. He has had no angina since that time while performing his usual activities or exercising on a low level treadmill exercise ECG.

Two weeks prior to this admission, a mild angina returned at the rate of one or two pains per week. The day prior to admission, this man was awakened by chest heaviness which was unrelieved by several sublingual nitroglycerin tablets. The patient came to the emergency room the next afternoon, about ten hours after the initial discomfort. The discomfort was relieved in the emergency room by two more nitroglycerins, a 10mg nifedipine tablet, and 3mg of intravenous morphine sulfate. The patient denied any shortness of breath, diaphoresis, nausea, emesis, or near-syncope.

Physical examination showed a blood pressure of 106/60mmHg, a pulse rate of 88 beats per minute, and respirations of 18 per minute. His lungs had bilateral basal crepitant rales and the heart showed an atrial gallop (S_4), and a soft grade 2/6 apical systolic murmur. This twelve lead ECG was obtained:

1. **The twelve lead ECG showed:**
   - A. Anterior wall myocardial infarction.
   - B. Inferior wall myocardial infarction.
   - C. Premature ventricular beat.
   - D. Complete right bundle branch block.
   - E. Complete left bundle branch block.

2. **Which of the following would be appropriate in a therapeutic plan?**
   - A. Admission to a coronary care unit.
   - B. Serial ECGs with continuous ECG monitoring.
   - C. Serial cardiac enzymes.
   - D. Intravenous or intracoronary thrombolysis.
   - E. All of the above.

(continued on page 322)

Because 50% of hypertensive patients drop out in their first year[1]...



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Side effects generally were mild and transient. Dizziness and asthenia were the most common. Others reported significantly more frequently than with placebo were nasal congestion, peripheral edema, somnolence, nausea, palpitations, and blurred vision. Incidence of syncope (1.0%) was not significantly different from placebo.

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Brief Summary

CLINICAL PHARMACOLOGY: Pharmacodynamics: Clinical studies of terazosin used in once-a-day (majority) and b.i.d regimens with total doses usually in the range of 5-20mg/day, in patients with mild or moderate hypertension. Because terazosin, like all alpha antagonists, can cause large falls in blood pressure after the first dose or first few doses, the initial dose was 1mg in virtually all studies, with subsequent titration to a specified fixed dose or titration to a specified blood pressure end point.

Blood pressure responses were measured at the end of the dosing interval (usually 24 hrs.) and effects were shown to persist throughout the interval, with usual supine responses 5-10mmHg systolic and 3.5-8mmHg diastolic greater than placebo. The responses in the standing position tended to be somewhat larger, although this was not true in all studies. The magnitude of blood pressure responses was similar to prazosin and less than hydrochlorothiazide (in a single study). In measurements 24 hrs. after dosing, heart rate was unchanged.

Limited measurements of peak response (2-3 hrs. after dosing) during chronic terazosin administration indicate that it is more than twice the trough (24 hr.) response, suggesting some attenuation of response at 24 hrs., presumably due to a fall in blood terazosin concentrations at the end of the dose interval. This explanation is not established with certainty and is not consistent with the similarity of blood pressure response to once-a-day and b.i.d. dosing. With the absence of an observed dose-response relationship over a range of 5-20mg, i.e., if blood concentrations fall to the point of providing less than full effect at 24 hrs., a shorter dosing interval or larger dose should lead to increased response. Measure blood pressure (BP) at the end of the dose interval; if response is not satisfactory, patients may be tried on a larger dose or b.i.d. regimen. The latter should be considered if side effects, such as dizziness, palpitations, or orthostatic complaints, are seen within a few hours after dosing.

The greater BP effect associated with peak plasma concentrations (first few hours after dosing) appears somewhat more position-dependent (greater in the erect position) than the effect of terazosin at 24 hrs. In the erect position there is a 6-10 bpm increase in heart rate in the first few hours after dosing. During the first 3 hrs. after dosing 12.5% of patients had a systolic pressure fall of 30mmHg or more from supine to standing, or standing systolic pressure below 90mmHg with a fall of at least 20mmHg, compared to 4% of a placebo group.

INDICATIONS AND USAGE: Indicated for the treatment of hypertension.

CONTRAINDICATIONS: None known

WARNINGS: Syncope and "First-dose" Effect: Terazosin, like other alpha-adrenergic blocking agents, can cause marked hypotension, especially postural hypotension, and syncope in association with the first dose or first few doses. A similar effect may occur if therapy is interrupted for more than a few doses. Syncope has been reported with other alpha-adrenergic blocking agents in association with rapid dosage increases or introduction of another antihypertensive drug. Syncope may be due to an excessive postural hypotensive effect, although occasionally the syncopal episode has been preceded by severe supraventricular tachycardia with heart rates of 120-160 bpm.

To decrease the likelihood of syncope or excessive hypotension, always initiate treatment with a 1mg dose at bedtime. The 2mg and 5mg tablets are not indicated as initial therapy. Increase dosage slowly, and add additional antihypertensive agents with caution. Caution patients to avoid situations where injury could result if syncope occurs during initiation of therapy.

In early studies, where increasing single doses up to 7.5mg were given at 3 day intervals, tolerance to the first dose phenomenon did not necessarily develop and the "first dose" effect was observed at all doses. Syncopal episodes occurred in 3 of 14 subjects given doses of 2.5, 5, and 7.5mg, which are higher than the recommended initial dose. Severe orthostatic hypotension (BP 50/0mmHg) was seen in two others and dizziness, tachycardia, and lightheadedness occurred in most subjects. These adverse effects all occurred within 90 min. of dosing.

In multiple dose clinical trials involving nearly 2000 patients, syncope was reported in about 1% of patients, in no case severe or prolonged, and was not necessarily associated with early doses.

If syncope occurs, place patient in recumbent position and treat supportively. There is evidence that the orthostatic effect of terazosin is greater, even in chronic use, shortly after dosing.

PRECAUTIONS: *General. **Orthostatic Hypotension:*** While syncope is the most severe orthostatic effect of terazosin, other symptoms of lowered BP, such as dizziness, lightheadedness and palpitations, are more common, occurring in 28% of patients in clinical trials. Patients with occupations in which such events represent potential problems should be treated with particular caution.

Information for Patients: Make aware of possibility of syncopal and orthostatic symptoms, especially at initiation of therapy, and to avoid driving or hazardous tasks for 12 hrs. after the first dose, after a dosage increase, and after interruption of therapy when treatment is resumed. Caution to avoid situations where injury could result should syncope occur during initial therapy. Advise to sit or lie down when symptoms of lowered BP occur and to rise carefully from a sitting or lying position. Bothersome dizziness, lightheadedness, or palpitations should be reported to physician.

Tell patients that drowsiness or somnolence can occur, requiring caution in people who must drive or operate heavy machinery.

Laboratory Tests: Small but statistically significant decreases in hematocrit, hemoglobin, WBC, total protein and albumin were observed in clinical trials. The magnitude of decreases did not worsen with time. These findings suggest the possibility of hemodilution.

Drug Interactions: In controlled trials, terazosin was added to diuretics, and several beta-adrenergic blockers; no unexpected interactions were observed. Terazosin has also been used concomitantly without interaction in at least 50 patients on the following: 1) analgesic/anti-inflammatory (acetaminophen, aspirin, codeine, ibuprofen, indomethacin); 2) antibiotics (erythromycin, trimethoprim and sulfamethoxazole); 3) anticholinergic/sympathomimetics (phenylephrine HCl, phenylpropanolamine HCl, pseudoephedrine HCl); 4) antigout (allopurinol); 5) antihistamines (chlorpheniramine); 6) cardiovascular agents (atenolol, hydrochlorothiazide, methyclothiazide, propranolol); 7) corticosteroids; 8) gastrointestinal agents (antacids); 9) hypoglycemics; 10) sedatives and tranquilizers (diazepam).

Carcinogenesis, Mutagenesis, Impairment of Fertility: HYTRIN was devoid of mutagenic potential when evaluated *in vivo* and *in vitro*.

HYTRIN, administered in feed to rats at doses of 8, 40, and 250mg/kg/day for 2 yrs., was associated with a statistically significant increase in benign adrenal medullary tumors of male rats exposed to the 250mg/kg dose. This dose is 695 X max. recommended human dose (20mg/55kg). Female rats were unaffected. HYTRIN was not oncogenic in mice when administered in feed for 2 yrs. at a maximum tolerated dose of 32mg/kg/day.

The absence of mutagenicity in a battery of tests, of tumorigenicity of any cell type in the mouse carcinogenicity assay, of increased total tumor incidence in either species, and of proliferative adrenal lesions in female rats, suggests a male rat species-specific event. Numerous other diverse pharmaceutical and chemical compounds have been associated with these tumors in male rats without supporting evidence for carcinogenicity in man.

Effects on fertility were assessed in a standard fertility/reproductive performance study in which male and female rats were administered oral doses of 8, 30 and 120mg/kg/day. Four of 20 male rats given 30mg/kg and 5 of 19 male rats given 120mg/kg failed to sire a litter. Testicular weights and morphology were unaffected. Vaginal smears at 30 and 120mg/kg/day appeared to contain less sperm than smears from control matings and good correlation was reported between sperm count and subsequent pregnancy.

Oral use for 1 or 2 yrs. elicited a statistically significant increase in testicular atrophy in rats exposed to 40 and 250mg/kg/day, but not in rats exposed to 8mg/kg/day (> 20 X max. recommended human dose). Testicular atrophy was observed in dogs dosed with 300mg/kg/day (> 800 X max. recommended human dose) for 3 months but not after 1 yr. when dosed with 20mg/kg/day. This lesion has also been seen with Minipress®.

Pregnancy: Teratogenic effects: Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women and the safety of terazosin in pregnancy has not been established. HYTRIN is not recommended during pregnancy unless potential benefit justifies potential risk to mother and fetus.

Nonteratogenic effects: In a peri- and post-natal development study in rats, significantly more pups died in the group dosed with 120mg/kg/day (> 300 X max. recommended human dose) than in the control group during the 3-week post-partum period.

Nursing Mothers: It is not known whether terazosin is excreted in breast milk; therefore, exercise caution when administering terazosin to a nursing woman.

Pediatric Use: Safety and effectiveness have not been determined.

ADVERSE REACTIONS: The prevalence of adverse reactions has been ascertained from 14 placebo-controlled studies conducted primarily in the U.S. The studies involved once-a-day administration of terazosin as monotherapy or in combination with other antihypertensive agents, at doses ranging from 1 to 40mg. All adverse events reported during these studies were recorded as adverse reactions. Adverse events where the prevalence rate in the terazosin group was at least 5%, where the prevalence rate for the terazosin group was at least 2% and was greater than the prevalence rate for the placebo group, or where the reaction is of particular interest are summarized below. Only asthenia, blurred vision, dizziness, nasal congestion, nausea, peripheral edema, palpitations and somnolence were significantly ($p < 0.05$) more common in patients receiving terazosin than in patients receiving placebo. Other events include **[%TERAZOSIN-%PLACEBO]:** asthenia (11.3%-4.3%), back pain (2.4%-1.2%), blurred vision (1.6%-0%), depression (0.3%-0.2%), dizziness (19.3%-7.5%), dyspnea (3.1%-2.4%), edema (0.9%-0.6%), headache (16.2%-15.8%), impotence (1.2%-1.4%), libido decreased (0.6%-0.2%), nasal congestion (5.9%-3.4%), nausea (4.4%-1.4%), nervousness (2.3%-1.8%), pain-extremities (3.5%-3%), palpitations (4.3%-1.2%), paresthesia (2.9%-1.4%), peripheral edema (5.5%-2.4%), postural hypotension (1.3%-0.4%), sinusitis (2.6%-1.4%), somnolence (5.4%-2.6%), tachycardia (1.9%-1.2%), weight gain (0.5%-0.2%).

Adverse reactions were usually mild or moderate in intensity but sometimes were serious enough to interrupt treatment. Adverse reactions that were most bothersome as judged by being reported as reasons for discontinuation of therapy by at least 0.5% of the terazosin group and being reported more often than in the placebo group **[%TERAZOSIN-%PLACEBO]** are: asthenia (1.6%-0%), blurred vision (0.6%-0%), dizziness (3.1%-0.4%), dyspnea (0.9%-0.6%), headache (1.3%-1%), nasal congestion (0.6%-0%), nausea (0.8%-0%), palpitations (1.4%-0.2%), paresthesia (0.8%-0.2%), peripheral edema (0.5%-0.4%), postural hypotension (0.5%-0%), somnolence (0.6%-0.2%), syncope (0.5%-0.2%), tachycardia (0.6%-0%).

Additional adverse reactions have been reported, but these are not distinguishable from symptoms that might have occurred in the absence of exposure to terazosin. The following additional adverse reactions were reported by at least 1% of 1987 patients who received terazosin in clinical studies or during marketing experience: abdominal pain, abnormal vision, anxiety, arrhythmia, arthralgia, arthritis, bronchitis, chest pain, cold symptoms, conjunctivitis, constipation, diarrhea, dry mouth, dyspepsia, epistaxis, facial edema, fever, flatulence, flu symptoms, gout, increased cough, insomnia, joint disorder, myalgia, neck pain, pharyngeal pain, pruritus, rash, rhinitis, shoulder pain, sweating, tinnitus, urinary frequency, urinary tract infection, vasodilation, vomiting.

DOSAGE AND ADMINISTRATION: Dose and dose interval (12 or 24 hrs.) should be adjusted according to BP response.

Initial Dose: 1mg at bedtime. Observe the initial dosing regimen strictly to minimize potential for severe hypotensive effects.

Subsequent Doses: Slowly increase dose to achieve desired BP response. Usual dose range is 1mg to 5mg once a day. Some patients may benefit from doses up to 20mg/day. Doses over 20mg do not appear to provide further BP effect. Doses over 40mg have not been studied. Monitor BP at the end of dosing interval to assure control is maintained. It may be helpful to measure BP 2-3 hrs. after dosing to see if maximum and minimum responses are similar, and to evaluate symptoms which can result from excessive hypotensive response. If response is substantially diminished at 24 hrs. consider an increased dose or b.i.d. regimen. **If administration is discontinued for several days or longer, reinstitute therapy using initial dosing regimen.** In clinical trials, except for the initial dose, the dose was given in the morning.

Use With Other Drugs: Caution should be observed when terazosin is administered concomitantly with other antihypertensive agents (e.g., calcium antagonists) to avoid the possibility of significant hypotension. When adding a diuretic or other antihypertensive agent, dosage reduction and retitration may be necessary.

August, 1987 **Abbott Health Care Products, Inc.** North Chicago, IL 60064 7083834

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4. Deger G: Effect of terazosin on serum lipids. *Am J Med* 1986;80 (suppl 5B):82-85. 7083834

OBITUARIES

****Eggers, John F.,** Sycamore, died August 17, 1987 at the age of 77. Dr. Eggers was a 1935 graduate of Northwestern University Medical School, Chicago.

***Ellis, Joseph G.,** Marion, died August 13, 1987 at the age of 52. Dr. Ellis was a 1962 graduate of the Stanford University School of Medicine, Palo Alto, California.

****Gieser, Paul Kenneth,** Wheaton, died August 1, 1987 at the age of 78. Dr. Gieser was a 1935 graduate of Northwestern University Medical School, Chicago.

***Guenther, David C.,** Quincy, died September 2, 1987 at the age of 29. Dr. Guenther was a 1983 graduate of the Southern Illinois University School of Medicine, Springfield.

***Hanrahan, Joseph P.,** Rock Island, died August 9, 1987 at the age of 57. Dr. Hanrahan was a 1955 graduate of the Tulane University School of Medicine, New Orleans, Louisiana.

***Henry, Marvin D.,** Olympia Fields, died August 17, 1987 at the age of 64. Dr. Henry was a 1946 graduate of the University of Illinois College of Medicine, Chicago.

Karolus, Herbert E., Dwight, died August 15, 1987 at the age of 82. Dr. Karolus was a 1934 graduate of the Medical College of Wisconsin, Milwaukee.

***Meany, Robert,** Oak Lawn, died August 24, 1987 at the age of 74. Dr. Meany was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Parsons, Gamaliel L., Jr.,** Chicago, died August 3, 1987 at the age of 66. Dr. Parsons was a 1947 graduate of the Meharry Medical College School of Medicine, Nashville, Tennessee.

****Penhale, Kenneth W.,** St. Thomas, Ontario, Canada, died July 13, 1987 at the age of 85. Dr. Penhale was a 1935 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Romence, Harvard L.,** Springfield, died September 1, 1987 at the age of 76. Dr. Romence was a 1938 graduate of the University of Michigan Medical School, Ann Arbor.

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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Evaluating Capitation Payments

What Are Your Odds?

When you sign a capitation contract, what are the odds that you can break even or make a profit? Are the odds in your favor or stacked against you? Evaluating payment in a capitation contract has been compared to learning how to play a game of chance. In roulette and in contracting, it's important to know the rules.

In capitation contracts, instead of paying a fee for services provided, the HMO pays a fixed amount each month (the capitation fee) for each plan member who chooses you. Generally speaking, you are financially responsible or "at risk" for providing covered services regardless of your actual cost. How great is the risk that your actual costs will exceed the aggregate capitation fees you receive?

Health insurance companies are in the business of measuring similar risks by using what is called "actuarial analysis." An actuary predicts the rate at which a health service will be utilized by the insured population. The utilization rate is used to establish the company's premium. HMOs establish the premiums they charge by using an actuarial analysis based on utilization rates too, and a percentage of the premium (capitation fee) is paid you. Along with a percentage of the premium, a component of the risk "shifts" to you. Is the percentage of the premium paid you commensurate with your risk?

Who Is Covered By the Plan?

In roulette, the population is simple. There are always 18 reds and 18 blacks. But what is the "patient-mix" of the HMO plan population? Do you know the breakdown according to age, sex, employment and place of residence? Does the plan include high-risk age groups? Is it being marketed to employment groups with particular health care needs or to groups known to utilize health care providers more frequently than others? How many members does the plan have? How many of them can be predicted to use you for covered services? Are there enough members to adequately spread the risk? What are the enrollment projections?

What Services Are Your Financial Responsibility?

You cannot determine if the capitation fee is adequate without knowing which specific services are your financial responsibility. However, many contracts do not list the covered services in detail. Instead you may see vague language, such as "covered services are those services usually and customarily provided," or "covered services are those services covered by the plan."

Some contracts define covered services by reference to another contract—the subscription agreement. The subscription agreement is the contract between the HMO and the employer or individual subscriber. Unless each subscription agreement which offers a different level of benefits is attached to your contract as an exhibit, defining covered services by reference to the subscription agreement does not help either.

After you have a detailed list of the services you must pay for, your next step is to determine whether

the HMO may add services without your consent and without a corresponding increase in the capitation payment. Some contracts allow the HMO to do just that. Others give you the right to terminate the contract if the change in benefits has a bad effect on you, but not the right to renegotiate the capitation amount. Some contracts do state that no additional services will be required. Once you know what your "patient-mix" is and what service you must provide, your next step is to determine your actual costs.

What Are Your Actual Costs?

What is the cost of a routine medical exam, including medical history? What is the cost of injectibles, including administration? Of outpatient x-ray and laboratory tests? Of physical or radiation therapy? Of emergency care? Do you know your costs for required ancillary services, such as treatment for alcoholism and drug abuse? What about eye examinations, hearing screening and chemotherapy? What are your costs for well child care and allergy testing and treatment? The services for which you are financially responsible will vary greatly, depending upon whether you are an IPA or a multi-specialty group with its own surgical and diagnostic facilities or you are under contract as an individual physician. But your task is identical: To determine the actual cost of each service for which you are financially responsible.

Now you know your patient mix, what services you are financially responsible for and your actual cost for each service. Your next step is to estimate how often services will be utilized.

What Is the Utilization Rate?

Many HMO contracts provide for termination or financial sanctions if the physician's (or IPA's) utilization rate exceeds that set by the plan. The utilization rate is critical therefore, in determining not only the financial feasibility of the capitation payment, but also whether the contract as a whole is one you can live with. Over a period of time an IPA or group will develop its own utilization data which it can use to compare with the utilization rates of the HMO. Then it can determine whether the rates used by the HMO are reasonable and consistent with sound medical practices. If you do not have your own data to compare with the HMO's it is prudent to critically examine the assumptions used by the HMO in establishing its projected utilization rates. Are the rates based on the plan's actual experience? Or are the rates based on historical experience which has been adjusted to the particular "patient mix" of the plan? How do the projected utilization rates of the plan compare with the plan's past and current experience?

If you multiply your actual cost of providing services by the utilization rate for the services, the result is your predicted cost of providing care to members. If you compare this number with the predicted payment from the plan (*i.e.*, the capitation fee multiplied by the number of members) you should be in a position to assess your risk.

Because you're an informed physician who recognizes the complexity of these contracts, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide objective comments on any HMO, PPO or IPA contract. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor.

This column has been limited to a discussion of ways to evaluate capitation payments. An upcoming column will address stop-loss insurance and withhold and incentive pools, all critical issues in capitation contracts. ◂

All Member Conference November 7, 1987

Managing Change

The ISMS All Member Conference will be held Saturday, November 7, at the Hyatt Oak Brook Hotel. A multifaceted program will feature seminars, workshops and a mock malpractice trial. Physicians and spouses who attend will gain tools to stay on top of today's ever-changing medical practice environment.

Registrants for the conference should plan to arrive at the Hyatt Oak Brook by 6:00 on Friday evening, November 6, for a "get acquainted" cocktail reception.

The ISMIE Network will sponsor an 8:00 Saturday morning overview of the professional liability insurance marketplace. This breakfast traditionally provides an open forum for questions and concerns.

At 9:00 the formal program will begin with a mock malpractice trial based upon actual cases from the files of the Illinois State Medical Inter-Insurance Exchange. A focus group of Illinois citizens will act as jury for the mock trial, and sequester to debate the case while the day's program continues.

The first didactic presentation at 11:00 will consider the upcoming 1988 elections, and how their outcome will affect legislative goals—specifically caps on noneconomic losses in medical malpractice cases. Most important, physicians will learn about how they can become effective activists in electoral politics.

The luncheon speaker is Larry Speakes, who formerly served as President Ronald Reagan's chief spokesman. A former press assistant to Presidents Gerald Ford and Richard Nixon, Mr. Speakes will consider how members of the media influence public policy—and what physicians can do to enlist their support.

Afternoon sessions will begin with a session on managing malpractice risks in the office and the hospital, followed by specialty-specific breakout sessions.

Attendees will have an opportunity to learn the results of focus group debate in the mock malpractice trial. Beginning at 4:00, ISMIE experts will analyze the jury's decision with the aid of videotaped excerpts from their deliberations.

Conference registration of $50 for ISMS and ISMS Auxiliary members and $100 for nonmembers will cover all materials and refreshments. Those who wish to attend may complete and return the coupon on the facing page or await a more complete program to arrive by mail. ◀



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als & Objectives

he conclusion of this nference, participants will able to: (1) identify factors ociated with new options professional liability urance in Illinois; (2) under- nd some of the common ors that can lead patients le suit and be aware of ventive strategies to help id such suits; (3) appre- e how the political process acts on the professional ility climate in Illinois; and understand the process adjudicating medical mal- ctice suits and associated tegies for defending such s. The program has been roved for 7 hours of Cate- y 1 CME credit for pur- es of the AMA Physician's ognition Award.

What's it like to be on trial for malpractice? Why do patients sue their doctors? What's happening in the Illinois insurance market? And what's the outlook for the future?

Over the past decade, Illinois' malpractice climate has been marked by volatile and continuous change. Liability issues affect medical practice in a multitude of subtle ways.

This year's ISMS All Member Conference is designed to provide answers to some of the questions facing physicians in today's medical environment.

The Malpractice Marketplace

This one-hour session sponsored by the Illinois State Medical Inter-Insurance Exchange Network will overview Illinois' professional liability insurance marketplace. Special emphasis will be placed on new initiatives to provide insurance protection to physicians—specifically the Risk Retention Act and the concept of "channeling."

Managing Risk in the Office and the Hospital

This three-hour session will feature case data compiled by the Illinois State Medical Inter-Insurance Exchange to identify frequent causes of malpractice claims. A general discussion will precede specialty-specific breakout sessions. Preventive measures, such as sound record-keeping practices and good patient communications, will be addressed.

Looking Forward to 1988 Elections

Hard-fought legislative victories have reduced the number of nuisance suits filed against Illinois doctors. But a comprehensive solution to the malpractice problem awaits further legislative reform. Some legal limit—or "cap"—on damage awards for noneconomic factors is essential. But legislation for caps will not pass in 1989 unless favorably disposed legislators are elected in 1988. During a special one-hour session, physicians will gain a perspective of important House and Senate races along with a practical "short course" on how to help elect sympathetic candidates to the General Assembly.

The Malpractice Trial

The volume of medical malpractice suits increases the likelihood that a doctor will find himself a defendant in a malpractice trial. A two-hour "mock trial" will be presented to help physicians understand what happens in court. The trial will be based on actual malpractice cases and physicians and attorneys from the Illinois State Medical Inter-Insurance Exchange will provide expert analysis of the events that take place.

Registration Information

The registration fee for the All Member Conference is $50 for ISMS and ISMS Auxiliary members. Nonmember fees are $100. All fees are waived for residents and students.

Registration materials will be mailed to all ISMS members in a few weeks. Further information is available through the ISMS offices: 312/782-1654 or 1/800/782-ISMS.

Managing Change

Illinois State Medical Society All Member Conference

Saturday November 7, 1987 Hyatt Oak Brook Hotel

Mail to: ISMS; Twenty North Michigan Avenue; Suite 700; Chicago, IL 60602

☐ **Yes! I'd like more information about the ISMS All Member Conference.**

Name

Address

City State Zip

Area Code: ( )
Telephone

MANAGING CHANGE

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

A conservative approach to treating scoliosis consisting of electrical stimulation of muscles on the concave side, exercise therapy, and back bracing was used on 169 children with curves of 25 degrees or less. Implanted electrodes resulted in five complications: two pneumothoraces; two intercostal nerve stimulations; and one infection. Surface electrodes used by others are reported to lead to improvement in 18% of cases; no progression in 54%; and progression in 28%. (Herbert, M., Bobechko, W.: *Orthopedics* 10:8, 1125-32, 1987)

The insertion of a viscoelastic shoe insert and its effect on pain in back and legs was evaluated in 100 nursing students. The insert was given to 50 of these students for a period of five weeks. Pain was evaluated prior to the insertion of the elastic inserts and students continued their nursing activities. The fifty students wearing the shock-absorbing viscoelastic inserts showed a shift in their pain centers from the back towards their lower extremities. This lasted a shorter period of time than in the control group. (Tooms, R., *et al.*: *Orthopedics* 10:8, 1143-7, 1987)

A retrospective study of 4,874 patients aged 50 or younger with a diagnosis of migraine equivalent or vascular headaches showed 20 patients with brain infarction. Angiographically, most were located in the posterior cerebral artery, and 18 of these showed no symptomatology. Twenty-five percent of all cases of cerebral infarction are migraine associated. (Broderick, J., Swanson, J.: *Arch Neurol* 44:8, 868-71, 1987)

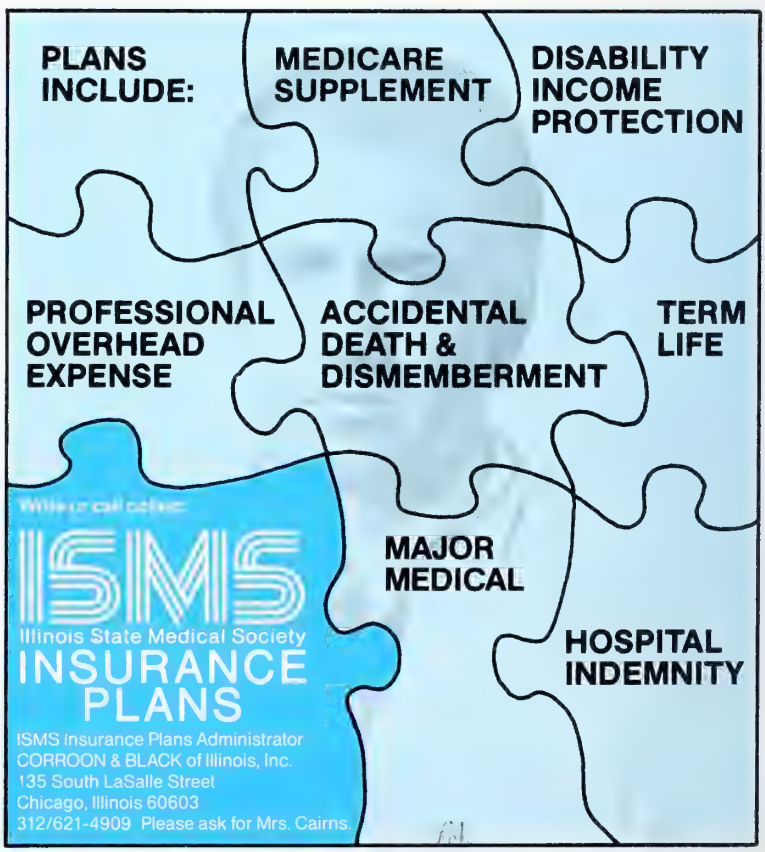
A broad spectrum of diseases are associated with IgM monoclonal gammopathies. Follow-up of these patients should be indefinite. In 430 patients who were followed long term, 56% had no definitive etiology, 17% had Waldenstrom's macroglobulinemia, 7% had lymphoma, 5% had chronic lymphocytic leukemia, 1% had primary amyloidosis, and 14% had other malignant lymphoproliferative diseases. More than two-thirds died, most commonly of a lymphoid malignant process. The median duration of time from recognition of the M protein until the development of a malignant lymphoid disease ranged from 4-9 years. (Kyle, R., Garton, J.: *Mayo Clin Proc* 62:8, 719-31, 1987)

SOLVE YOUR PROTECTION PUZZLE

The insurance puzzle...are there pieces missing from your picture?

As a member of ISMS, you can realize substantial benefits by participating in society-approved insurance plans. Designed and administered by professionals in cooperation with ISMS, this program could be the answer to your personal and professional needs. While your requirements receive individual attention, you also enjoy the economies of ISMS group purchasing power.

COMPLETE PROGRAM PROFILE OFFERED WITHOUT OBLIGATION



The Illinois Thoracic Surgical Society has agreed to furnish brief summaries of case reports related at their regular meetings. These case reports, published on a "space available" basis, are edited by Ralph Butz, M.D., assistant chief, thoracic surgery, Edward Hines Veterans Administration Hospital, Hines, Illinois.

Infected Intrapulmonary Bronchial Cyst

Case Presentation by Frank Milloy, M.D./Lake Forest
Comments by Louis R. Head, M.D./Chicago

Dr. Frank Milloy: This 40-year-old white woman sought medical help for fever and productive cough. Sputum was thick and yellow, but not foul-smelling. She had no hemoptysis. Figure 1 shows this patient's chest x-ray at the time of hospital admission and Figure 2 shows her x-ray taken one year earlier as part of a routine medical evaluation. She had never experienced symptoms referable to her lung before this admission, nor had she traveled to any areas associated with endemic pulmonary infections. Examination revealed only right upper lobe rales. Treatment with penicillin eliminated her symptoms and partially cleared the air fluid level on chest x-ray. Bronchogram showed no bronchiectasis. (Figure 3)

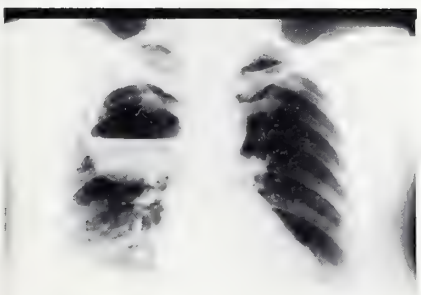


Figure 1
PA chest x-ray at time of admission. Patient was symptomatic.



Figure 2
PA chest x-ray taken one year earlier than Figure 1 as a "routine check up." Patient was asymptomatic.

A right upper lobectomy was performed. Histologic examination of the cyst showed a thin wall with bronchial epithelial lining.



Figure 3
Bronchogram made after patient became asymptomatic.

Dr. Louis R. Head: The management of this patient's evolving lung disease was rapid and effective. During observation of an asymptomatic pulmonary cavity, progression in size and the advent of infection foretold the presence of a condition that would continue to be troublesome. Because of its technical simplicity, adequacy of resection, and low mortality and morbidity, lobectomy was a very satisfactory solution to this problem.

Before surgery, the use of antibiotics, bronchoscopy, and a bronchogram decreased the risks of spreading infection, eliminated proximal bronchial obstruction from stenosis, foreign bodies, or tumors as predisposing conditions, and assured the surgeon that other underlying and widespread pulmonary disease was not present, thus freeing the procedure from constraints of lung tissue conservation.

Although alternative management procedures, *e.g.,* continued observation, tube drainage, or intrapulmonary dissection of the bronchial cyst could be effective and efficient, their outcome would not be as certain. Pulmonary blebs, bullae, or cysts, once infected, have been seen to spontaneously regress and disappear after treatment of the infection. Presumably this happens because the infection destroys the epithelial lining and closes the connections to the alveoli and bronchi, allowing the air to be resorbed and the fibrous lining to approximate and heal. This sequence of events requires time, occurs infrequently, and could subject the patient to recurrent episodes of infection, possible septicemia, and further damage to adjacent tissue. Likewise, Monaldi's drainage through a thoracotomy tube could facilitate spontaneous closure should infection eliminate the bronchial epithelial lining. It, too, runs the same risks and chances of success as does simple observation. Ideally, resection of the cyst alone and closure of its bronchial and alveolar connections would have left the patient with more pulmonary reserve than is available at present. But this is technically more difficult, could spread residual infection, and has the possibility of leaving residual pockets of bronchial epithelium which could cause future problems.

The origin of bronchial cysts outside the lung parenchyema can only be explained as arising from developmental misappropriation of bronchial tissue. Intrapulmonary cysts, however, are not as readily explained, since acquired cavities have been seen to epithelialize, and bronchiectatic or stenotic bronchi have been seen to expand into similar structures.

Behavior of this type of cyst is variable. During the development of surgical techniques for their treatment, during the 1940s and '50s, Monaldi's tube drainage was employed for blebs and bullae, but avoided in epithelialized cysts. To distinguish these conditions, a scope was inserted after the first stage, so that a diagnosis could be made. Observations during respirations were interesting. Although atmospheric pressure existed within these structures due to introduction of the scope, the movement of air into and out of them was seen. Usually, multiple openings were present, with air entering during expiration or coughing and the openings closing during inspiration. Thus these entities represented trapped air, either stationary in size when resorption equalled air entry, decreasing in size when little entry occurred, or gradually expanding with severe coughing or an imbalance between entry and resorption. In the present case, it is likely that bronchitis with severe coughing upset a previously balanced cyst, causing it to enlarge and, with poor drainage, to become infected.

Bronchography continues to provide essential information in many conditions. The development of flexible bronchoscopes and the knowledge of possible deleterious effects on lung function have resulted in its less frequent use. Progress in the development of newer bronchography materials, such as tantalum dust, although promising, have slowed, due to poor absorption of alveolar dust and a tendency to explode. As usual, this sort of occurrence tends to cause everyone to pull back on the throttle. ◀

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 172, No. 4
October 1987

ISMS Organization

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp, who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected to fill the post in May, 1968. He was succeeded by the present executive administrator, Mr. Alexander R. Lerner, in May, 1981. Another milestone was reached in October, 1984, when the headquarters offices relocated to Twenty North Michigan Avenue, Chicago 60602.

The Society published early transactions in book form, presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. VanDellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established under chairmanship of Dr. J. William Roddick, Jr., to review and determine clinical content for the *IMJ*. Dr. Roddick completed his term as chairman in June of 1987. The Editorial Board reports to the ISMS Publications Committee.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938. Illinois also led the way for medical participation in political action when it formed the first medical political action committee, IMPAC, in 1960. The Illinois State Medical Inter-Insurance Exchange, an insurance reciprocal providing comprehensive professional liability insurance for Illinois physicians, was formed in 1976. Concomitantly, Illinois State Medical Insurance Services, Inc., was formed as a wholly-owned subsidiary of ISMS to act as Attorney-in-Fact for the Exchange.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

ISMS Code of Ethics

WHEREAS, The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient; and

WHEREAS, As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self; therefore be it

RESOLVED, That the following Code of Ethics be adopted by the Illinois State Medical Society not as laws, but standards of conduct which define the essentials of honorable behavior for the physician:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Adopted by the Illinois State Medical Society
House of Delegates
November, 1981

Illinois State Medical Society Constitution and Bylaws

Adopted, 1903
As Amended, 1987

Constitution

Article I. Name

The name and title of this organization shall be the Illinois State Medical Society.

Article II. Purposes of the Society

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Society.

Article IV. Composition of the Society

The Society shall consist of active members and such other members as the Bylaws may provide.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

Article VI. Officers

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

Article VII. Board of Trustees

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

Article VIII. Conventions and Meetings

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

Article IX. The Seal

This Society shall have a common seal with power to break, change or renew the same when necessary.

Article X. Amendments

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. Members. Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. Regular Members. Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. Emeritus Members. Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

C. Retired Members. Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions in the health care field after retiring from medical practice.

D. Service Members. Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

E. Distinguished Members. Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

F. In-Training Members. In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

G. Student Members. Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. Discrimination of Membership. Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. Tenure and Termination.

A. Tenure of Membership. The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be *prima facie* evidence of membership so long as he complies with the provisions of this Constitution and Bylaws. A member shall hold only one type of membership at any one time.

B. Termination of Membership. Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed,

providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES AND ASSESSMENTS

Section 1. Dues. Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal.* Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. Reduction and Remission of Dues. Regular members may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member based upon annual review and recommendation of the component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. Assessments. In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III. EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. Composition. The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-Elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section, 9) one delegate elected by the Medical Student Section and 10) one delegate elected by the Hospital Medical Staff Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each recognized medical specialty society, as approved by the ISMS Board of Trustees.

Section 2. Delegates. Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. Affiliate Group Delegates. There shall be a Resident Physicians Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. There shall be a Hospital Medical Staff Section, which shall be comprised of ISMS members elected to represent individual hospital medical staffs. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. Time and Place of Meetings.

A. Annual Meeting. The House of Delegates shall meet in an annual session and may meet in an interim session upon call of the Board of Trustees. The time and place of the annual meeting shall be as the House determines.

B. Interim Meeting. The Board of Trustees may schedule an interim session of the House of Delegates between annual meetings of the House if it determines that there is sufficient, relevant business. An interim meeting of the House should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. An interim meeting should be held in a district other than that of the preceding annual meeting.

Section 5. Quorum. Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. Special Meetings. Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. Registration. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. District Division. The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. Order of Procedure. The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. Privilege of the Floor. The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. Introduction of Resolutions and Other Business. All resolutions must be introduced by a voting member of the

House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters 30 days prior to the annual or interim meeting. Resolutions received after the above date must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. The only business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.
2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.
3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Medical Student Section which are considered urgent and accepted by the Committee on Rules and Order of Business.

Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. Judicial Panel. The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

CHAPTER V. ELECTION OF OFFICERS

Section 1. Officers. The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. Elections. All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and unfinished business at the final session of the House of Delegates.

Section 3. Terms of Office. The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. The President. The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform other duties as custom and parliamentary usage may require. He shall also appoint such task forces as may be needed by the Society.

Section 2. The President-Elect. The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Administrator, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. The Vice Presidents. The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice presidency, the second vice president will become first vice president.

Section 4. Successor to President-Elect. In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. The Speaker. The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. The Vice Speaker. The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. The Secretary-Treasurer. In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom, or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. Delegates and Alternate Delegates to the American Medical Association. Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates

until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. Composition. The Board of Trustees shall consist of twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. The Chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the chairman of the Board of Directors of the Illinois State Medical Insurance Services, Inc., shall sit as an ex-officio member having all privileges except the right to vote. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—DuPage County.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. Duties. The duties of the Board of Trustees are executive and custodial.

A. Executive Duties. The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

   The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. Custodial Duties. The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

   No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

   All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board. The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

   All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective. Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

Section 3. Executive Administrator. The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. Meetings. The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. Organization.

A. Chairman. The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. Duties of the Chairman. The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.

Section 6. Quorum. Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. County Societies. The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. Publication. The Board of Trustees shall provide and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. Bonding. The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. Duties of Trustees. Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. Vacancies. If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. The Benevolence Fund. Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem appropriate to be held in a fund of a separate incorporated entity known as "The Illinois State Medical Benevolence Fund, Inc." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. Contributions

and bequests to the Illinois State Medical Benevolence Fund, Inc., shall be deposited forthwith in said fund.

Section 13. Audit and Financial Statement. The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Physicians elected to district committees shall serve a three year term of office. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. Committee Structure. The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. Committees Reporting Directly to the Board of Trustees
C. House of Delegates Committees
D. Board of Trustees Committees

Section 2. Councils.

A. The Medical-Legal Council shall be concerned in the areas of:
   1. Liaison with the Illinois Bar Association
   2. Liaison with courts, particularly where impartial medical testimony is involved.
   3. Implementation of the Impartial Medical Testimony Rule
   4. Legal aspects of medical practice other than in the area of mental health
   5. Licensing and standards of practice
   6. Quackery
   7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
   1. Federal and state legislation—analysis and communication
   2. Legislative liaison—both state and federal
   3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
   1. Liaison with medical schools, curricula, etc.
   2. Health manpower and training
   3. Internships, residencies, etc.
   4. Scientific assembly
   5. Student loans
   6. Continuing medical education

D. The Council on Economics shall be concerned in the areas of:
   1. Ongoing relationships with third parties
   2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:
   1. The provision of medical care and health services in the public and private sectors
   2. Emergency medical services
   3. Health care of the poor, aged and those in rural areas
   4. Maternal and child health
   5. Nutrition
   6. Workmen's compensation
   7. Environmental and community health
   8. Rehabilitation
   9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
   1. Publicity and promotion
   2. News media relations
   3. Exhibits and public service programming
   4. Religion and medicine
   5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
   1. Facilities and services
   2. Liaison with Department of Mental Health
   3. Legal aspects of commitment, etc.
   4. Narcotics and dangerous drugs
   5. Alcoholism

Section 3. Organization of Councils.

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Medical Student Section and resident physician members nominated by the Governing Council of the ISMS Resident Physicians Section may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

   Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

   A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils and task forces, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of

concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

Section 4. Task Forces. A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of Trustees, shall be appointed by the President upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.

Section 5. Committees Reporting Directly to the Board of Trustees.

A. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as chairman of the committee.

B. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain liaison with various organizations as determined by the Board of Trustees.

C. Committee on Drugs and Therapeutics. The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

D. Health Data Committee. The Committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of various organizations as determined by the Board of Trustees.

E. Peer Review Appeals Committee. This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to local peer review committees and monitors activities around the state.

F. Committee on CME Accreditation. It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

G. Committee for the Impaired Physician. Committee for the Impaired Physician consists of physicians who provide assistance to impaired physicians and those concerned about them for problems related to alcohol or drug dependence, physical disabilities, mental or emotional disturbances. The Committee provides information, sponsors educational programs, offers counseling, conducts interventions, provides monitoring and serves as the recovering physician's advocate. All activities are provided in a confidential and professional manner.

Section 6. House of Delegates Committees. House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.

It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.

C. Committee on Tellers and Sergeants-at-Arms shall:
1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

G. Judicial Panel Committee. The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal prac-

tices. The panel accepts appeals after a case has been heard at the county or district level.

Section 7. Organization of House of Delegates Committees.

A. Immediately after the organization of the House of Delegates at each meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 8. Board of Trustees Committees. The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote. The chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the chairman of the Board of Directors of the Illinois State Medical Insurance Services, Inc., shall sit as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society. This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence program to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

G. CME Accreditation Appeals Panel. The panel will consist of seven trustees. It will function as a hearing committee when a CME sponsor appeals a decision of the CME Accreditation Committee. The hearing shall be conducted in conformance with written procedures adopted by the Board of Trustees.

H. The Building and Capital Equipment Committee shall consist of the Chairman of the Board, the President, the President-Elect, the Secretary-Treasurer, the Chairman of the Finance Committee, and the Immediate Past Chairman of the Board, provided that person is a Trustee.

I. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

J. Committee on Insurance. This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.

K. Third Party Payment Processes Committee. This committee will report to the Board on matters of socioeconomic import which are assigned by the chairman.

Section 9. Powers of the Board of Trustees. The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 10. Term of Membership. The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws of ISMS and the constituent society.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving his application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. Members of the Illinois State Medical Society shall be bound by the Constitution and Bylaws of ISMS.

CHAPTER XI. ETHICAL RELATIONS

Part 1. Component Medical Society. Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings.*

Part 2. District Ethical Relations Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee serving its area function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relation Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

Part 3. Offenses.

A. Disciplinary action may be taken against any member of a component society when:
   1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
   2. He has been adjudged or otherwise recorded as guilty by his component society of:
      a. acts of serious misconduct as a physician; or
      b. a violation of the Constitution or Bylaws of his component society, or of the code of Medical Ethics promulgated by the Illinois State Medical Society; or
   3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

Part 4. Standards and Procedures.

A. The committee, in its deliberations, shall evaluate acts by the standards established in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.

B. Disciplinary action may be initiated by the component society or the ISMS upon receipt of formal written charges filed by any person, alleging violations of any of the offenses enumerated in Part 3 of this chapter. The person filing the complaint may submit it to either the county where the accused physician holds membership or the county where the alleged incident occurred.

   Written charges received by the Illinois State Medical Society shall be referred to the secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

Part 5. Penalties. The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership.

The recommendation to censure shall mean an entry will be made in the accused physi-

cian's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) month period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to this expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

Part 6. Decision by Component Medical Society.

A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description of these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.

B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

Part 7. Judicial Panel. A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

A notice of appeal shall be filed with the ISMS Judicial Panel by one of the parties within 30 days after receiving notice of a decision from the component society. Within 15 days after the required filing date for appeal, the party requesting the appeal shall file a written statement with the Judicial Panel which shall include a description of the errors believed to have occurred during the prior proceedings or assertations of the substantive grounds for requesting the Appellate Hearing.

A party may be granted an appeal hearing if: 1) There is reason to believe that procedural error(s) ocurred which significantly affected the outcome of the case; 2) There is a showing that those who conducted the initial hearing acted with bias; 3) The evidence upon which the decision was based was not sufficient to support the decision; 4) The evidence was not properly received or considered; or 5) In the sole discretion of the Judicial Panel, there were other reasons which adversely governed the proceedings and denied due process rights to the party requesting the appeal.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an initial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws. In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees. The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings,* to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

Part 8. Due Process Safeguards. In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such

due process protections.

CHAPTER XII PEER REVIEW

Part 1. Definitions. Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted by the county society where the physician holds membership or where the incident which served as the basis for the peer review complaint occurred. Ethical relations issues identified during deliberations of the county peer review committee, or where appropriate, the District Peer Review Committee may be referred to either the county or district ethical relations committee, as deemed appropriate by the county (district) committee.

Should an adverse decision be made against a physician by a county society where the reviewed practitioner does not hold membership, that decision will have the weight and effect of a decision made by his own county society. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

Part 2. Component Society Procedures.

A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.

B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.

C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.

D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review certain local proceedings of the component society or district committee. A petition for an appeal must set forth one of the following grounds as a basis for the appeal:

1. PROCEDURAL ERROR—The peer review proceeding was not conducted in accordance with written rules established by the component society, district committee, or the Illinois State Medical Society.
2. BIAS—The proceeding was conducted in a biased or arbitrary manner.
3. INCOMPLETE INFORMATION—If information not available to the component society or district committee is submitted to the State Peer Review Appeals Committee, the committee will first determine the relevancy of the new information. The case will be referred to the component society or district committee for reconsideration if the information is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

Part 3. District Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

Part 4. Illinois State Medical Society Procedures.

A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

The Peer Review Appeals Committee shall review appeals of decisions of component or district peer review committees in accordance with the provisions of Part 2 (D) of this chapter. The state committee shall determine the validity of the alleged grounds and, if found valid, remand the case to the local or district committee for a rehearing. If the alleged grounds are found invalid, the decision of the district or county committee shall be deemed to be reaffirmed. The decision of the Peer Review Appeals Committee shall be forwarded first to the county or district committee and then to the appellant. The state committee shall have authority to assign cases to district peer review committees in accordance with Part 3 of this chapter. Decisions of the state committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.

C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any

article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

CHAPTER XVI. INDEMNIFICATION

Part 1. Third Party Actions. The Illinois State Medical Society ("Society") shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative, including all appeals (other than an action, suit or proceeding by or in the right of the Society) by reason of the fact that he is or was a director, trustee, officer, or employee of the Society, or is or was serving at the request of the Society as a director, trustee, officer, or employee of another corporation, partnership, joint venture, trust, or other enterprise, against expenses (including attorneys' fees), judgments, decrees, fines, penalties, and amounts paid in settlement actually and reasonably incurred by him in connection with such action, suit or proceeding if he acted in good faith and in a manner which he reasonably believed to be in or not opposed to the best interests of the Society and, with respect to any criminal action or proceeding, had no reasonable cause to believe his conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of *nolo contendere* or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he reasonably believed to be in or not opposed to the best interests of the Society and, with respect to any criminal action or proceeding, had reasonable cause to believe that his conduct was unlawful.

Part 2. Derivative Actions. The Society shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action or suit, including all appeals, by or in the right of the Society to procure a judgment in its favor by reason of the fact that he is or was a director, trustee, officer, or employee of the Society, or is or was serving at the request of the Society as a director, trustee, officer, or employee of another corporation, partnership, joint venture, trust, or other enterprise, against expenses (including attorneys' fees) actually and reasonably incurred by him in connection with the defense or settlement of such action or suit if he acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the Society, except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been finally adjudged to be liable for negligence or misconduct in the performance of his duty to the Society unless and only to the extent that the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for such expenses as such court shall deem proper.

Part 3. Rights After Successful Defense. To the extent that a director, trustee, officer or employee has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in Section 1 or 2, or in defense of any claim, issue or matter therein, he shall be indemnified against expenses (including attorney's fees) actually and reasonably incurred by him in connection therewith.

Part 4. Other Determination of Rights. Except in a situation governed by Section 3, any indemnification under Section 1 or 2 (unless ordered by a court) shall be made by the Society only as authorized in the specific case upon a determination that indemnification of the director, trustee, officer, or employee is proper in the circumstances because he has met the applicable standard of conduct set forth in Section 1 or 2. Such determination shall be made (a) by a majority vote of trustees acting at a meeting at which a quorum consisting of trustees who were not parties to such action, suit or proceeding is present, or (b) if such a quorum is not obtainable (or even if obtainable), and a majority of disinterested trustees so directs, by independent legal counsel (compensated by the Society) in a written opinion, or (c) by the affirmative vote in person or by proxy of the membership entitled to vote in the election of trustees, without regard to voting power which may thereafter exist upon a default, failure, or other contingency.

Part 5. Advances of Expenses. Expenses of each person indemnified hereunder incurred in defending a civil, criminal, administrative, or investigative action, suit, or proceeding (including all appeals), or threat thereof, may be paid by the Society in advance of the final disposition of such action, suit, or proceeding as authorized by the Board of Trustees, whether a disinterested quorum exists or not, upon receipt of an undertaking by or on behalf of the director, trustee, officer, or employee, to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Society.

Part 6. Nonexclusiveness; Heirs. The indemnification provided by this Article shall not be deemed exclusive of any other rights to which those seeking indemnification may be entitled as a matter of law or under the Articles, the Regulations, any agreement, vote of the membership, any insurance purchased by the Society, or otherwise, both as to action in his official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a director, trustee, officer, or employee and shall inure to the benefit of the heirs, executors, and administrators of such a person.

Part 7. Purchase of Insurance. The Society may purchase and maintain insurance on behalf of any person who is or was a director, officer, or employee of the Society, or is or was serving at the request of the Society as a director, trustee, officer, or employee of another corporation, partnership, joint venture, trust, or other enterprise against any liability asserted against him and incurred by him in any such capacity, or arising out of his status as such, whether or not the Society would have the power to indemnify him against such liability under the provisions of this Resolution or of the General Not For Profit Corporation Act.

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1987-1988

Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, AMA delegates and alternate delegates, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

Established policy must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

Professional Policies

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Abuse and Neglect of the Elderly

Physicians, nurses and other health care personnel are reminded to be aware of possible instances of abuse and neglect of the elderly and are encouraged to report suspected cases appropriately.
(1982 Annual Meeting—Reviewed by Board, 1987)

Abuse of Children

ISMS urges all state health agencies and family service agencies which become involved in child abuse cases, to conduct, promptly, necessary investigation of the fam-

ily environment prior to the release of the child for return to the same home where the abuse occurred.

ISMS opposes abuse of children in Illinois schools.

(1981 Annual Meeting—Amended, 1987 Annual Meeting)

Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists.

(1975 Annual Meeting—Reviewed by Board, 1987)

Advertising Guidelines, Professional

See appendix for state law on physician advertising.

(Amended 1985 Annual Meeting)

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity, by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics.

(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socioeconomic impacts, should be encouraged.

(Amended, 1980 Annual Meeting—Reviewed by Board, 1987)

Ambulance Services

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards.

(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Anaphylactic Reactions to Insect Stings

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.

(1981 Annual Meeting—Reviewed by Board, 1986)

Animals in Research and Education

The Illinois State Medical Society endorses the position that research and medical education, which involves the use of animals, is necessary to enhance the medical care of the public.

(1983 Annual Meeting)

Assessments

Medical staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds or other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments.

(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Athletic Performance, Inappropriate Use of Procedures to Improve

The Illinois State Medical Society opposes the use of such items as, but not limited to, hormones, drugs and blood transfusions solely to improve athletic performance.

(1985 Annual Meeting)

Athletic Programs

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment.

(Amended 1980 Interim Meeting—Reviewed by Board, 1987)

Audits and Surveys

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additional, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned.

(Amended, 1980 Interim Meeting—Reviewed by Board, 1987)

Autopsies

Because the autopsy has public health and educational benefits for medical science, the family of the deceased individual and the public at large, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.

(Amended, 1984 Annual Meeting)

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

(1971 Annual Meeting—Reviewed by Board, 1986)

Blood Availability

Since the use of a replacement or penalty fee has been eliminated in this state, ISMS encourages component societies to promote the public's full acceptance of the concept of truly altruistic blood donation and community responsibility.

The Illinois State Medical Society and its component societies should strongly encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.

(Amended, 1985 Annual Meeting)

Blood Services

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county.

The Illinois State Medical Society will attempt to educate physicians and their patients through its publications regarding the inability of contracting AIDS by donated blood. "Designated blood donations" are an inappropriate means of dealing with the AIDS problem and inordinately tie up blood supplies.

(Amended, 1984 Annual Meeting)

Breast Cancer Screening

The Illinois State Medical Society Supports the American Cancer Society guidelines for breast cancer screening as a means to identify and treat early stage breast cancers.

(1986 Annual Meeting)

Cardiopulmonary Resuscitation

ISMS encourages basic cardiac life support training in Illinois high schools.

(1981 Annual Meeting—Reviewed by Board, 1986)

CPR and First Aid Training for Health Club Employees, Mandatory

ISMS endorses the concept that persons

responsible for monitoring or instructing others in health and fitness facilities be certified in basic cardiopulmonary resuscitation.
(1984 Annual Meeting)

Child Safety Restraints

ISMS supports and encourages public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourages physicians and others to discuss their benefits with all parents. Physicians are encouraged to learn about important safety features which have proven effective.
(1981 Interim Meeting—Reviewed by Board, 1986)

Chronic Care Patients

The Illinois State Medical Society encourages medical schools and residency training programs to develop curricula addressing the issues of utilization of community resources and the strategies for dealing with the long-term medical, rehabilitation and social needs of chronic care patients.
(1984 Annual Meeting)

Code of Ethics

The following Code of Ethics represents standards of conduct defining the essentials of honorable behavior for the physician. They are not laws.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

(1981 Interim Meeting—Reviewed by Board, 1986)

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness.

Section IV of the AMA Principles of Medical Ethics states that: "A physician shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law."

The Illinois State Medical Society reaffirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of confidentiality of the doctor-patient relationship as it relates to the patient record and will take an active role in uncovering any violation of the doctor-patient relationship by officials and personnel of review organizations and will take whatever steps necessary to eliminate the breach of confidence.
(Amended, 1987 Annual Meeting)

Confidentiality and Utilization Review

In order to protect patient care and confidentiality, physicians in Illinois should use considered judgment when discussing any patient's care over the telephone.

That the Illinois State Medical Society establish objection to utilization review performed solely upon the basis of admitting diagnosis without actual hospital record review as being inadequate, incomplete and incapable of accuracy.

Physicians in Illinois who receive patient permission for a case discussion by telephone from their patients on behalf of third party payors may, ethically and in their own best judgment, make a determination as to whether a reasonable charge for their time and expertise in providing such telephone case review discussions should be made, if any, for these medical services.
(1987 Annual Meeting)

Continuing Education

The Illinois State Medical Society shall continue its strong support of voluntary continuing medical education in Illinois and the intrastate accreditation of quality CME programs. Continuing education is one of the basic functions of the Illinois State Medical Society, which is committed to scientific advancement, humanization of medicine, and development of cooperation and rapport with the public.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have a primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities.

Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.
(Amended, 1986 Annual Meeting)

Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a nonproven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services, should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.
(Amended, 1983 Annual Meeting)

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.
(1977 Annual Meeting—Reviewed by Board, 1986)

Death, Legal Definition of

A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an individual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.

(Amended, 1981 Interim Meeting—Reviewed by Board, 1986)

Diagnosis Related Groups

ISMS supports the concept that the individual hospital medical staffs' responsibility is to ensure that appropriate quality of care for patients shall not be compromised in the Diagnosis Related Groups (DRG) process.
(1983 Annual Meeting)

DRG Payments and Cost of Procedures

ISMS encourages hospitals to establish a mechanism whereby physicians will have ready access, upon admission of patients, to information about expected DRG payments and charges for hospital procedures.
(1984 Annual Meeting)

Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Discrimination Against Physicians

The quality of medical training is an appropriate concern in the recruiting and credentialing of physicians. However, it is inappropriate to discriminate against any physician because of national origin or geographic location of medical education.
(1985 Annual Meeting)

Drinking Age, Legal

A uniform national legal drinking age of 21 years should be established by all states.
(1984 Annual Meeting)

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Only those generic drugs which are actually bio-equivalent should be included in the Illinois Formulary for the Drug Product Selection Program of the Illinois Department of Public Health.

ISMS urges IDPH to monitor and enforce proper generic drug substitution by pharmacists according to bio-equivalency based on the formulary.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.
(Amended, 1982 Annual Meeting)

Drunk Drivers

ISMS supports laws providing for stiffer sentencing of drunk drivers and encourages the judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol.
(1981 Interim Meeting—Reviewed by Board, 1986)

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.
(1976 Annual Meeting—Reviewed by Board, 1986)

Emergency Medical Care, Provision of

Emergency care should be provided to all patients, based only on medical necessity. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.
(1) All EMS systems should develop protocols which provide for cooperation between a physician on the scene of an emergency and paramedics responding to the emergency call; (2) It is the obligation of the physician who happens upon the scene of a medical emergency to provide reasonable identification to paramedic personnel that he/she is a physician and, if appropriate, has training in emergency procedures. If the paramedics are not in uniform, they should provide identification to the physician that they are certified by the state to provide emergency medical care; (3) When paramedics are present, a physician should avoid involvement in resuscitation measures that exceed his or her prior training or experience; (4) Where voice communication with the medical control facility is available, the paramedics and the physician on the scene should interact with the local medical control authority; (5) Where voice communication is not available, the physician on the scene of an emergency should cooperate with and abide by the EMS protocols, and permit the paramedic team to function within their guidelines and the EMS law; and (6) In a nonemergency situation, where the EMS system provides the only available ambulance service in an area, a private physician and the medical director of the EMS system should make every effort to cooperate in the treatment and transportation of the patient, either through written protocols or voice contact, prior to requesting the ambulance service.

The Illinois State Medical Society encourages the State of Illinois and the business community to provide an emergency medical kit and qualified individuals for the administration of appropriate emergency care at functions where a very large number of individuals are present.

Insurance plans which cover emergency medical services should pay for such services regardless of where they are rendered.
(Amended, 1987 Annual Meeting)

Experimental Medical Procedures

With respect to experimental medical procedures, physicians must adhere to and affirm the following:

- Accepted ethical standards;
- The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;
- Appropriate Illinois statutory or regulatory requirements.

(Amended, 1981 Annual Meeting—Reviewed by Board, 1986)

Eye Care

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or administer eye medication for therapeutic purposes and services. ISMS vigorously opposes any legislative attempt in Illinois to allow non-physicians to prescribe or use medications other than approved topical agents used for diagnosis.
(Amended, 1987 Annual Meeting)

Fees, Informing Patients of

Where feasible and desirable, physicians should provide patients with information regarding fees and, where practicable, discuss this information prior to providing care.
(1984 Annual Meeting)

55 M.P.H. Speed Limit

The Illinois State Medical Society opposes an increase in the 55 mile per hour speed limit.
(1981 Annual Meeting—Reviewed by Board, 1986)

Firearms

The Illinois State Medical Society supports the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition. It opposes any state legislation in Illinois that would prohibit the enactment or enforcement of county or municipal ordinances restricting the ownership, purchase, sale, transport or transfer of firearms or firearm ammunition.
(1982 Annual Meeting—Reviewed by Board, 1987)

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.
(Amended, 1986 Annual Meeting)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.
(1977 Interim Meeting—Reviewed by Board, 1986)

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.
(1967 Annual Meeting—Reviewed by Board, 1986)

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured as long as the plan has a demonstrated physician-supported patient care management program in effect.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs for limited license practitioners without direct supervision and responsibility for patient care by a physician licensed to practice medicine in all its branches in Illinois.
(Amended, 1986 Annual Meeting)

Health Insurance, Voluntary Plans

ISMS supports private, voluntary catastrophic health insurance, including freedom of choice of physician. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for ambulatory diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

When insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed. If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do. Under such circumstances, recouping of the money from the patient should be the responsibility of the insurance company, or its agent, that committed the error and not the responsibility of the physician.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physicians' charges above insurance benefit allowances are excessive;
- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;
- Suggesting that physicians perform alternative surgical procedures;
- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;
- Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and
- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1982 Annual Meeting)

Health Maintenance Organizations

Every insurance identification card for a health maintenance organization should have the designation, "HMO" clearly printed on the front of the insurance card, along with the warning that unauthorized services may not be reimbursed and along with a 24-hour telephone number which can be called for payment approval in the event of an emergency.
(1982 Interim Meeting—Reviewed by Board, 1987)

Health Planning

ISMS supports health planning on a local and voluntary basis with input by a significant number of physicians licensed to practice medicine in all its branches. Planning and implementation of the plan (regulation) are two different processes and should be kept separate and distinct. ISMS opposes the imposition of the public utility type of regulation of the medical profession. The concept of certificate of need requires continued evaluation.
(Amended, 1987 Annual Meeting)

Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.
(1974 Annual Meeting—Reviewed by Board, 1986)

Health Systems Agencies

The Illinois State Medical Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim measure, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with federal SHPDA designated criteria.
(1981 Annual Meeting—Reviewed by Board, 1986)

HSA Fund Solicitation

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.
(1980 Annual Meeting—Reviewed by Board, 1986)

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.
(1977 Annual Meeting—Reviewed by Board, 1984)

Hospices

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either in-patient settings, home care or a combination of both. Bereavement

counseling is provided for the survivors.
(1981 Annual Meeting—Reviewed by Board, 1986)

Hospital and Medical Staff Committees

A hospital's medical staff should be an autonomous, self-governing body whose members participate in the activities of medical staff and hospital committees. However, physicians should distinguish between committees over which the hospital gives the staff authority and responsibility and those over which the hospital has full responsibility. Medical staff committees should be those composed solely of members of the medical staff and concerned with the quality of medical care. Hospital committees should be viewed as those created for some general hospital function and composed mainly of hospital personnel, which may or may not include medical staff members.
(1982 Interim Meeting—Reviewed by Board, 1987)

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. The hospital medical staff and only the medical staff should establish minimum limits of professional liability insurance coverage for their own medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on the medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of the hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

ISMS recognizes it is the right and duty of 1) a medical staff organization to evaluate the credentials of all applicants for medical staff privileges, according to objective, predetermined criteria of acceptability and 2) the hospital governing body to grant privileges to those applicants found acceptable and desirable as members of the medical staff.
(Amended, 1985 Annual Meeting)

Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society shall support physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients.

A physician's hospital privileges should be based on clinical competency and quality of care.
(Amended, 1985 Annual Meeting)

IDPA Drug Manual

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will continue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bioequivalence.
(1981 Annual Meeting—Reviewed by Board, 1986)

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed by the local or state medical society.

ISMS continues to support the need for physical examinations of, and updating of immunizations for school children in the State of Illinois on school entry, at 5th grade and 9th grade levels, in keeping with preventive medicine measures presently in existence in the state. Measures to assure compliance of the school health mandates by school districts in Illinois should be maintained.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.
(Amended, 1984 Annual Meeting)

Impaired Physicians

The Illinois State Medical Society and its individial members should recognize the importance and need to promote, support and participate in state, local and hospital activities to prevent, recognize and overcome impairment among medical students, residents and practicing physicians.
(1985 Annual Meeting)

Idemnification

Physicians who serve state or local agencies as volunteers, independent contractors or employees, should be provided legal defense, indemnification and appropriate immunity by the governmental agency.
(1987 Annual Meeting)

Indigent, Care of the

The Illinois State Medical Society reaffirms organized medicine's commitment to provide care to those who need medical care, regardless of their ability to pay for it.

However, personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.
(Amended, 1982 Interim Meeting—Reviewed by Board, 1987)

Infants Born with Disabilities, Care and Treatment of

The Illinois State Medical Society urges all Illinois medical staffs to develop and conduct educational programs for their members involved in the care of handicapped infants, regarding advances in such care, as well as laws and regulations affecting the delivery of these infants.
(1984 Annual Meeting)

Informed Consent

ISMS endorses the position that disclosures made to patients conform to the general practices of the medical profession in the same or a similar community or locality, which are disclosures that a reasonable medical practitioner would make under the same or similar circumstances.

ISMS opposes legislative definition of informed consent.

However, it favors enactment of legislation providing that consent for furnishing

medical treatment to an adult patient, who is not capable of consenting, may be given or refused by the patient's competent spouse, parent, adult child or adult sibling.
(Amended, 1982 Interim Meeting—Reviewed by Board, 1987)

Insanity as a Defense

ISMS supports the concept that a person may be found innocent of a crime by reason of having severe mental illness or retardation.

For a person to use insantiy as a defense, the severity of the person's mental condition should be shown to exhibit an inability to know the nature of his conduct at the time of the offense, and that he was unaware that the act was wrong and personally or socially destructive to himself or someone else.

Testimony by medical experts on the nature of a person's mental condition should be limited to the diagnosis, mental state and motivation of an individual and not on whether the person is "sane" as determined by legal standards.

A person found innocent by reason of insanity should be provided treatment and ongoing supervision to ensure the public is protected, and when psychiatric treatment can no longer help an individual, who is still considered dangerous, that person should be transferred to a nonmedical facility for further supervision.
(1985 Annual Meeting)

Joint Commission on Accreditation of Hospitals

A "physician" (doctors of medicine or doctors of osteopathy) is defined as one who by education, training, experience, and licensure is able to practice medicine in all of its branches.

ISMS opposes the development of any JCAH Standard mandating medical staff membership to anyone other than physicians. ISMS encourages the Joint Commission on Accreditation of Hospitals to require greater than a majority of fully licensed physician membership on the medical staff executive committees in acute care general hospitals. ISMS urges JCAH to recognize the importance of the medical staff in credentialing and in monitoring the quality of care in the hospital and it encourages the development of the appropriate environment within the hospital so that both the medical staff and limited licensed practitioners may work together for the best interests of the patient.
(1983 Annual Meeting—Amended 1987 Annual Meeting)

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches.

The Illinois State Medical Society opposes any attempt to change the Illinois Clinical Laboratory Act by exempting commercial laboratories or free-standing laboratories and clinics operated by hospitals from meeting the standards of this act.
(Amended, 1985 Annual Meeting)

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physician's judgment as to which procedures are appropriate and in the best interests of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.
(1974 Annual Meeting—Reviewed by Board, 1987)

Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered a surgical procedure.
(1981 Annual Meeting—Reviewed by Board, 1986)

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.
(1976 Annual Meeting—Reviewed by Board, 1986)

Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

It favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

It supports the philosophy that all medical education accepted for licensure to practice should be comparable.

Graduates of state medical schools are encouraged to practice medicine in Illinois and ISMS will utilize its organizational structure to develop positive incentives.

ISMS encourages primary care residency programs to establish educational activities in the rural and underserved areas of Illinois.
(Amended, 1982 Interim Meeting)

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coroner system, wherever practical.
(1971 Annual Meeting—Reviewed by Board, 1986)

Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.
(1979 Annual Meeting—Reviewed by Board, 1987)

Medical Psychotherapy

Medical psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and nonverbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medical Representation in Government Planning

Unless physicians appointed to the boards and committees of other organizations are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

ISMS supports the concept that when federal funds are available to the states, representative physicians should actively participate in the distribution of these funds.
(Amended, 1982 Interim Meeting—Reviewed by Board, 1987)

Medical Staff Participation in Accreditation Activities

Medical staff of a hospital should cooperate to achieve JCAH accreditation of their hospital.
(1982 Interim Meeting—Reviewed by Board, 1987)

Medical Staff Participation in Hospital Cost Containment Efforts

Physicians on a hospital's medical staff should encourage and cooperate in efforts to

see that hospital care is delivered in the most effective manner without compromising quality.
(1982 Interim Meeting—Reviewed by Board, 1987)

Medical Staff Relationship with County Medical Society

County medical societies are encouraged to form standing committees composed of medical society officers and representatives of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations and official and voluntary health related agencies in their community.
(1982 Interim Meeting)

Medical Supplies, In-Flight

The Illinois State Medical Society encourages air carriers to equip planes with an emergency kit on each flight and that flight crews be instructed in cardiopulmonary resuscitation procedures.
(1982 Interim Meeting—Reviewed by Board, 1987)

Medical Testimony, Expert Witnesses

An expert witness is defined as a physician licensed to practice medicine in all its branches, having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, relevant personal experience, practical familiarity and technical knowledge of the problems that are being considered, as well as knowledge of alternative forms of treatment, and was active in the practice of the medical subject under discussion at the time the incident occurred.
(Amended, 1987 Annual Meeting)

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.
(1980 Interim Meeting—Reviewed by Board, 1986)

Mental Health

A. The Importance of Mental Health Education and Services

ISMS recognizes the importance of mental health in the quality of a person's life and the devastating impact mental illness can have for an individual and one's family. Knowing that modern medicine has much to offer, ISMS supports the training of physicians in mental health care, the education of the public in recognizing mental illness and the development of private and public services for care.

B. The Physician's Role in Mental Health Services

ISMS recognizes the primacy of the physician in the diagnosis and treatment of mental illness. Involuntary psychiatric hospital certification of any patient must, without exception, involve a physician licensed to practice medicine in all its branches. However, the discharge of any patient from a psychiatric institution must remain the responsibility of a physician.

C. Continuing Medical Education for Department of Mental Health and Developmental Disabilities Physicians

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

D. Cooperation between County Medical Societies and DMHDD

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:
(1) Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle; (2) Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature; (3) Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician time available; (4) Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available areawide.

E. Patient Visits

The number of times a patient is seen should not be the sole criterion of the necessity or adequacy of psychiatric care. The level of care needed by the patient must be a major factor in determining the delivery of that care. Each hospital or hospital system should establish its own standard of psychiatric care to include the level of care needed by that patient, and should monitor the adequacy of psychiatric care by means other than frequency of visits.

F. Community Mental Health Services

ISMS supports and encourages the development of community options for services to the chronically mentally ill in the private and public sectors, although the Society opposes using such alternatives to inappropriately discharge these persons to inadequate services and living conditions, thereby increasing the number of homeless mentally ill.
(Amended, 1987 Annual Meeting)

Motorcycle Helmets

All Illinois physicians should encourage their patients who use motorcycles to wear protective helmets, pointing out the efficacy of such helmets in preventing death during collisions.
(1982 Annual Meeting)

Multiphasic Screening

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the State of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Newborns, Prenatal Development of

The public concern about the macroenvironment's effects on human health should be expanded to include equal concern for a healthy intrauterine environment for the prenatal period of development of each child.
(1984 Annual Meeting)

Nurses—Shortage

The ISMS supports nursing education at all its levels.
(Amended, 1986 Annual Meeting)

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.
(1973 Annual Meeting—Reviewed by Board, 1986)

Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Occupational Health

Occupational health is an essential ingredient of employee welfare. The continued

adoption and development of occupational health programs in the private and public sectors should be encouraged.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.
(1978 Annual Meeting—Reviewed by Board, 1984)

Patient Care Records and Their Availability

Patient care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in case of psychiatric illness. In the case of nonhospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient, a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs to accomplish scientific review, peer review or other patient care improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees. ISMS will take all appropriate action to preserve the confidentiality of records and activities of medical staff committees.

Pursuant to a subpoena for records, a physician is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released, a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made.

Reference may be made 1979, Illinois Revised Statutes, Chapter 48, Section 138.8; Chapter 51, Sections 71, 73 and 101; Chapter 91½, Section 800ff.
(Amended, 1984 Annual Meeting)

Peer Review

See Chapter XII of the Bylaws.
(Amended, 1983 Annual Meeting)

The Illinois State Medical Society is opposed to review which is not conducted by one's peers. A "peer" is a currently licensed physician, licensed to practice medicine in all its branches, who is experienced in the medical question under consideration and, whenever possible, whose primary practice is in the community involved. The ISMS is opposed to utilization review conducted entirely by telephone or similar communications, with no recourse to review by a physician in the same region of the state, whose practice is in the same specialty.
(1986 Annual Meeting)

Physician-Patient Relationship

The Illinois State Medical Society encourages voluntary health organizations to work with the available local medical communities in providing referral and treatment of cancer patients so that existing physician-patient relationships are not breached.
(1984 Annual Meeting)

Physician Records, Privacy of

The Illinois State Medical Society will take appropriate action to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.
(Amended, 1984 Annual Meeting)

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches."
(Amended, 1982 Interim Meeting—Reviewed by Board, 1987)

Physician's Assistants

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.
(1980 Annual Meeting—Reviewed by Board, 1986)

Professional Associations

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.
(1979 Interim Meeting—Reviewed by Board, 1986)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for this liability coverage.
(Amended, 1978 Interim Meeting—Reviewed by Board, 1987)

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.
(1976 Annual Meeting—Reviewed by Board, 1984)

Provider Organizations, Exclusive

ISMS should monitor the development of health maintenance organizations, IPAs, preferred provider organizations, and exclusive provider organizations in Illinois and have this information available to assist ISMS members in their relationships with these organizations.
(1984 Annual Meeting)

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.
(1975 Annual Meeting—Reviewed by Board, 1986)

Public Aid

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multispecialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multispecialty care for Public Aid patients should be made available without extensive justification procedures.
(Amended, 1986 Annual Meeting)

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that

county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Rehabilitation

All physical rehabilitation activites should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.
(Prior to 1965—Reviewed by Board, 1986)

Reimbursement of Ambulatory Services

Third party payors should be encouraged to provide coverage for ambulatory surgery and diagnostic procedures. Final medical decisions must remain in the hands of the attending physician. However, the Illinois State Medical Society supports the concept of maximum utilization of ambulatory surgical services consistent with the doctor's judgment of the facilities available.
(Amended, 1982 Annual Meeting—Reviewed by Board, 1987)

Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.
(1980 Annual Meeting—Reviewed by Board, 1987)

Reimbursement for Outpatient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.
(1980 Annual Meeting—Reviewed by Board, 1986)

Reimbursement for Treating Medicaid Patients

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients.
(1981 Annual Meeting—Reviewed by Board, 1987)

Reimbursement, Physician

It is desirable to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician's right to choose which method of economic reimbursement for care that best suits the needs of that physician and his/her patients. Where appropriate, ISMS supports the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays. To the extent practicable, ISMS should strive to assist physicians in understanding alternative reimbursement systems, including but not limited to Usual and Customary or Reasonable (UCR).
(Amended, 1985 Annual Meeting)

Relationship with Third Party Payors

ISMS should provide appropriate guidance, education, and communication between the membership and third party payors.
(Amended 1986 Annual Meeting)

Risk Management

ISMS supports the policy that: (1) Hospital medical staffs recognize the relevance of hospital risk management programs to help protect the hospital, the medical staff and hospital personnel from unnecessary claims and lawsuits; (2) Risk management activity should not adversely affect the ability of a physician from exercising his legal and professional responsibilities to practice medicine and ensure quality care; and (3) The hospital medical staff should be the primary resource which works with the hospital to establish those elements of risk management which directly affect patient medical care.
(1986 Annual Meeting)

Seatbelt Use

The Illinois State Medical Society supports the voluntary use of seatbelts and other passenger restraint devices as effective methods of reducing injury and death in motor vehicle accidents. It supports state legislation requiring that all school buses be equipped with passenger safety restraints and other structural modifications to assure maximum impact safety.
(Amended, 1983 Annual Meeting)

Smoking

The Illinois State Medical Society, as a matter of policy, publicly adopts a vigorous stand against cigarette smoking because it is a major health hazard. The Society will work with other agencies inside and outside medicine to eliminate this contributory cause of death, disability and rising health care cost. ISMS will support appropriate legislative initiatives to communicate the risks of tobacco to all, particularly young people.

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and encourages medical staff action to make hospitals tobacco smoke-free, except for certain areas designated for smoking.

Physicians should refrain from smoking during professional patient visits. Exemplary abstinence during social contacts by physicians and their employees with the public in general is highly desirable. Literature and signs concerning the health hazards of smoking should be displayed in medical offices and other public places over which health care professionals have control.
(Amended, 1985 Annual Meeting)

Surgery, Reconstructive

Reconstructive surgery is surgery which is intended to correct deformities caused by disease or accident.
(Amended, 1985 Annual Meeting)

Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.
(1979 Annual Meeting—Reviewed by Board, 1986)

Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization over and above the judgment of the treating physician.
(1978 Annual Meeting)

Tobacco Farm Subsidies

The Illinois State Medical Society opposes the subsidization or price supports of tobacco farming.
(1982 Annual Meeting—Reviewed by Board, 1987)

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.
(1978 Annual Meeting—Reviewed by Board, 1986)

Withdrawing or Withholding Life-Prolonging Treatment

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his/her family or legal representative (if the patient is incompetent to act in his/her own behalf) should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient, whose death is imminent, to die.

In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act on his/her own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent, but a patient's coma is beyond doubt irreversible and there are adequate safe-guards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artifically or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweight its burdens. At all times the dignity of the patient should be maintained.
(1987 Annual Meeting)

Workers Compensation

The Illinois State Medical Society advocates a single radiologic examination to satisfy the medical requirements at a given time in the course of a workers compensation injury.
(1982 Annual Meeting)

ADMINISTRATIVE POLICIES

AMA-ERF

The AMA-ERF contributions for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by advising ISMS in writing.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1987)

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1987)

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.
(1978 Interim Meeting—Reviewed by Board, 1986)

Councils and Committees

It is the policy of the Board of Trustees to encourage evening or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.
(1981 Annual Meeting—Reviewed by Board, 1986)

Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Department of Registration and Education to the appropriate county society.
(1980 Interim Meeting—Reviewed by Board, 1986)

Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates.
(1980 Annual Meeting—Reviewed by Board, 1987)

Dues Stabilization, Membership

The Illinois State Medical Society should 1) carefully consider the delicate balance of dues and membership and 2) maintain reasonable dues within the context of budgetary reviews and long-range planning in order to preserve medicine's strength by member involvement and participation.
(1985 Annual Meeting)

Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates.

The Resident Physicians Section and the Medical Student Section shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1987)

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be

assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for elections as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

(1977 Annual Meeting—Reviewed by Board, 1987)

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.

(1978 Annual Meeting—Reviewed by Board, 1987)

Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.

(1981 Annual Meeting—Reviewed by Board, 1987)

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.

(Prior to 1965—Reviewed by Board, 1986)

Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal;*
2. Brief notice in Action Report, whenever possible, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(Amended, 1982 Annual Meeting—Reviewed by Board, 1987)

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

(Prior to 1965—Reviewed by Board, 1987)

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils or major committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except when emergency action is necessary because of unexpected vacancies.

Nomination for appointments to subcommittees, ad hoc committees, other minor committees of AMA or as AMA representatives to certain outside agencies may be made directly by the Chairman of the ISMS Board of Trustees, after consultation with the Chairman of the ISMS Delegation, without specific approval of the full Board of Trustees or AMA Delegation. Such action shall be reported to the Board of Trustees and the AMA Delegation.

Upon receiving notice that an Illinois physician has been nominated for AMA position by an organization other than ISMS, the Chairman of the ISMS Board of Trustees, pursuant to the recommendation of the Chairman of the AMA Delegation, shall inform AMA only whether or not the nominee is a member in good standing of ISMS.

(Amended, 1981 Interim Meeting—Reviewed by Board, 1987)

Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Board of Trustees.

(Amended, 1980 Annual Meeting—Reviewed by Board, 1987)

Legislation

All matters presented to the House of Delegates or Board of Trustees pertaining to state or federal legislation shall be reviewed by the Governmental Affairs Council, which shall evaluate its potential impact on the Society's current legislative efforts. The council shall submit its report to the Board of Trustees, which shall advise and recommend action to the House through the Chairman of the Board.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Governmental Affairs Council of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs and with Board approval shall work in close cooperation with any other society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee and with Board approval.

(Amended, 1981 Interim Meeting—Reviewed by Board, 1987)

Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.

(Amended, 1980 Annual Meeting—Reviewed by Board, 1987)

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the state society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.

(1978 Interim Meeting—Reviewed by Board, 1987)

National Library of Medicine

The Illinois State Medical Society supports the programs of the National Library of Medicine. Fees for subscribers should be based on the current accounting system rather than on total costs.
(1982 Interim Meeting)

Participation in Service Organizations

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors in training in Illinois and to those who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.
(Amended, 1985 Annual Meeting)

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.
(1976 Interim Meeting—Reviewed by Board, 1987)

Press

In order to provide the public with prompt and accurate information on all health-related matters, all county medical societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The state society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications.
(1980 Interim Meeting—Reviewed by Board, 1987)

Public Statements

Only officially designated persons may publicly speak for the society. The chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the society's policies and positions.
(1978 Annual Meeting—Reviewed by Board, 1987)

Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.
(1980 Annual Meeting—Reviewed by Board, 1987)

Reference Service

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1987)

Resident Physician Membership

Each regular member of ISMS is encouraged to recruit at least one resident physician member every year, with the regular member providing assistance to the resident in completing the application process for membership.

The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level.
(Amended, 1983 Annual Meeting)

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.
(1976 Interim Meeting—Reviewed by Board, 1987)

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Recognized medical specialty societies as approved by the Board of Trustees shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.
(1979 Annual Meeting—Reviewed by Board, 1987)

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.
(1974 Annual Meeting—Reviewed by Board, 1987)

Policy Manual Appendix

State Regulation on Physician Advertising

The Illinois legislature passed a new Medical Practice Act which governs advertising by physicians and which came into effect as of May 22, 1987. The Illinois Department of Registration and Education, which is responsible for implementation of the law, will provide regulations for implementation. The pertinent sections of the Medical Practice Act are as follows:

Section 26.

Any person licensed under this Act may advertise the availability of professional services in the public media or on the premises where such professional services are rendered. Such advertising shall be limited to the following information:

(a) Publication of the person's name, title, office hours, address and telephone number;

(b) Information pertaining to the person's areas of specialization, including appropriate board certification or limitation of professional practice;

(c) Information on usual and customary fees for routine professional services offered, which information shall include, notification that fees may be adjusted due to complications or unforeseen circumstances;

(d) Announcement of the opening of, change of, absence from, or return to business;

(e) Announcement of additions to or deletions from professional licensed staff;

(f) The issuance of business or appointment cards.

It is unlawful for any person licensed under this Act to use testimonials or claims of superior quality of care to entice the public. It shall be unlawful to advertise fee comparisons of available services with those of other persons licensed under this Act.

This Act does not authorize the advertising of professional services which the offeror of such services is not licensed to render. Nor shall the advertiser use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition.

Section 27.

It is unlawful and punishable under Section 59 for any person licensed under this Act to knowingly advertise that the licensee will accept as payment for services rendered by assignment from any third party payor the amount the third party payor covers as payment in full, if the effect is to give the impression of eliminating the need of payment by the patient of any required deductible or copayment applicable in the patient's health benefit plan.

As used in this Section, "advertise" means solicitation by the licensee or through another by means of handbills, posters, circulars, motion pictures, radio, newspapers, television or in any other manner.

Trustee District Committees

First District

David B. Littman, Highland Park, *Trustee*
Counties of Kane, Lake, McHenry

Ethical Relations Committee	Term Expires
Gerald J. Liesen, St. Charles, *Chairman*	1988
A. M. Rossetti, McHenry	1989
Donald M. Coder, Lake Forest	1990

Peer Review Committee	
James C. Pritchard, Geneva, *Chairman*	1990
Edward F. Wilt, Crystal Lake	1990
Albino T. Bismonte, Gurnee	1990

Second District

Ross N. Hutchison, Gibson City, *Trustee*
Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford

Ethical Relations Committee	Term Expires
William E. Erkonen, Streator, *Chairman*	1989
Julius M. Kowalski, Princeton	1989
Lawrence D. Lee, Manhattan	1988
Merle L. Otto, Frankfort	1988

Peer Review Committee	
D.G. Parkhurst, Kankakee, *Chairman*	1989
James B. Aplington, LaSalle	1988
Robert Bettasso, Ottawa	1988
Silvio Davito, Spring Valley	1988
Bernard J. Doyle, Peru	1988
William E. Ehling, Streator	1989
Alex J. Spadoni, Joliet	1988
Theodore W. Wagenknecht, Streator	1988
John H. Kendall, Joliet	1990

Third District

James H. Andersen, Oak Brook, *Trustee*
H. Constance Bonbrest, Chicago, *Trustee*
Alfred J. Clementi, Arlington Heights, *Trustee*
Audley F. Connor, Jr., Chicago, *Trustee*
Ulrich F. Danckers, River Forest, *Trustee*
Robert C Hamilton, Chicago, *Trustee*
M. Anita Johnson, Hickory Hills, *Trustee*
William J. Marshall, Olympia Fields, *Trustee*
Adriano S. Olivar, Chicago Heights, *Trustee*
Robert M. Vanecko, Chicago, *Trustee*

Fourth District

Lorris M. Bowers, Peoria, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren

Ethical Relations Committee	Term Expires
Jerry Ramunis, Galesburg, *Chairman*	1988
Kenneth E. Ambrose, Monmouth	1988
Even Kvelland, Geneseo	1990

Peer Review Committee	
James C. Parsons, Geneseo, *Chairman*	1988
Donald H. Dexter, Macomb	1989
William Dougherty, Moline	1990
Richard M. Flacco, Galesburg	1988
Lorin D. Whittaker, Jr., Peoria	1990
Thomas G. Cassidy, Peoria	1990

Fifth District

Michael C. Snyder, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon

Ethical Relations Committee	Term Expires
Richard H. Suhs, Springfield, *Chairman*	1989
Jack Means, Mason City	1990
A.L. Van Ness, Bloomington	1988

Peer Review Committee	
Albert Cunningham, Normal, *Chairman*	1989
Robert B. Perry, Lincoln	1988
Donald H. Yurdin, Springfield	1988

Sixth District

George T. Wilkins, Jr., Edwardsville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Edward K. DuVivier, Alton, *Chairman*	1989
Bernard M. Baalman, Hardin	1990
C.B. Lara, Pittsfield	1990
Robert M. Roy, Jr., Jacksonville	1990

Peer Review Committee

Walter Stevenson, III, Quincy, *Chairman*	1989
Robert G. England, Carlinville	1990
Robert F. Hamilton, Godfrey	1990
Robert C. Murphy, Quincy	1988
Edward F. Ragsdale, Alton	1989
James W. Sutherland, Quincy	1989

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Delbert H. Hahn, Jr., Decatur, *Chairman*	1988
E. Doyle Slifer, Taylorville	1989
E.F. Stephens, III, Centralia	1988

Peer Review Committee

H. Gale Zacheis, Decatur, *Chairman*	1989
Ruben Boyajian, Effingham	1989
Clarence G. Glenn, Decatur	1988
D.H. Rames, Vandalia	1988

Eighth District

Arthur R. Traugott, Urbana, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1989
Stanley R. Huffman, Charleston	1989
Charles L. Lansford, Urbana	1988
Gerald Mastio, Olney	1990

Peer Review Committee

George T. Mitchell, Marshall, *Chairman*	1990
Edward S. Warren, Danville	1988
R. C. Adams, Champaign	1988
Robert Swengel, Neoga	1990

Ninth District

Phillip D. Boren, Carmi, *Trustee*
Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Richard L. Morgan, Marion, *Chairman*	1988
Eli Borkon, Carbondale	1989
Paul P. Lorenz, Carbondale	1989

Peer Review Committee

Larry R. Jones, Harrisburg, *Chairman*	1990
Roger N. Klam, Carbondale	1990
Harry L. Lewis, Benton	1988
Charles K. Wells, Mt. Vernon	1988
William F. Hays, Herrin	1990

Tenth District

Ronald G. Welch, Belleville, *Trustee*
Counties of Monroe, Perry, Randolph, St. Clair, Washington

Ethical Relations Committee	Term Expires
H. P. Dexheimer, Belleville, *Chairman*	1988
Charles R. Frazer, E. St. Louis	1988
Edilberto F. Maglasang, Columbia	1988
Wm. A. Simmons, Belleville	1988

Peer Review Committee

Theodore L. Bryan, Belleville, *Chairman*	1990
Henry M. Hurd, Belleville	1988
Alan L. Liefer, Red Bud	1990
R. E. Schettler, Red Bud	1989

Eleventh District

Raymond A. Dieter, Jr., Glen Ellyn, *Trustee*
County of DuPage

Twelfth District

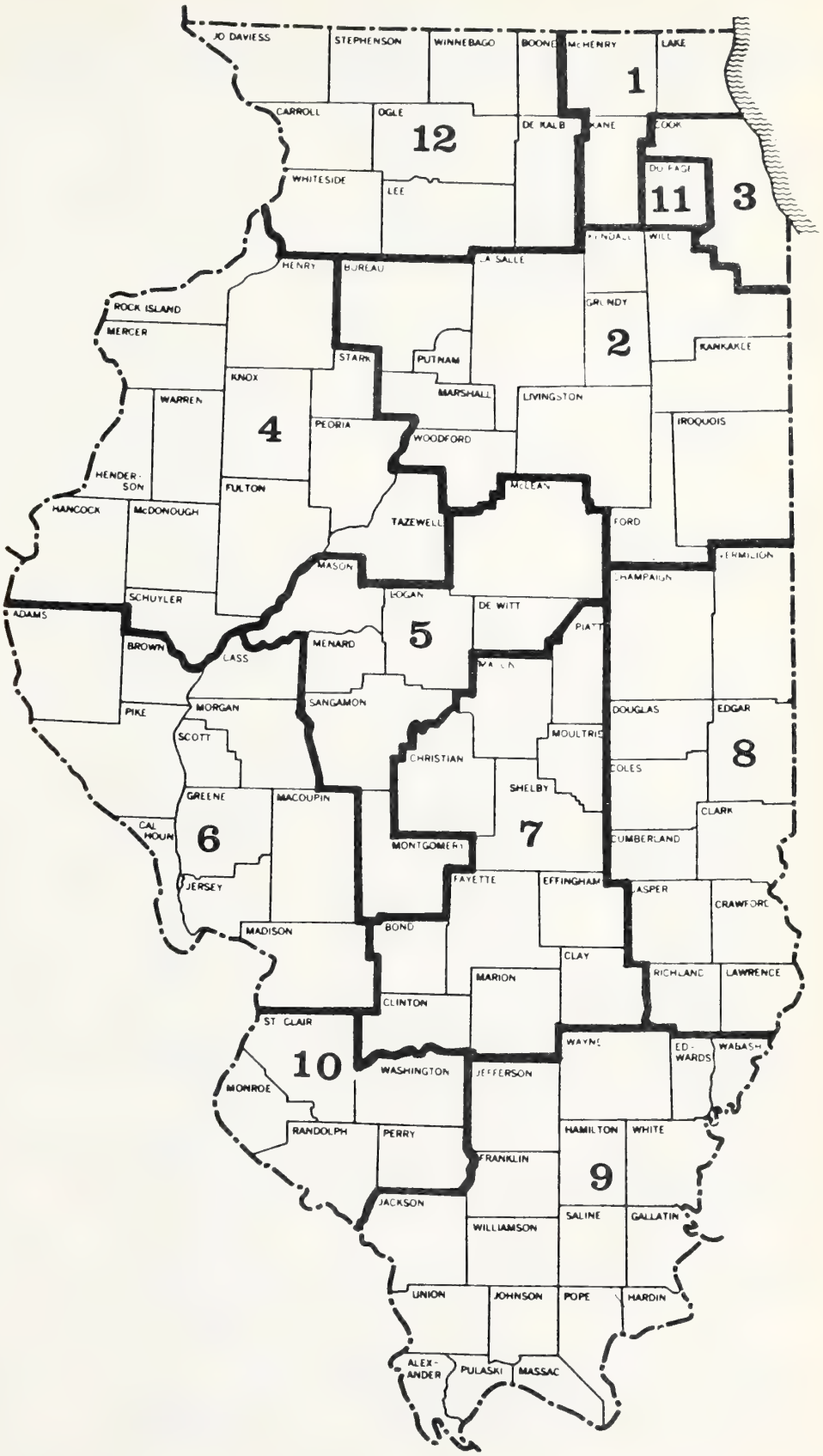
Raymond E. Hoffmann, Rockford, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Ethical Relations Committee	Term Expires
John H. Steinkamp, Belvidere, *Chairman*	1990
David K. Deets, Dixon	1989
Edward D. Maglietta, Freeport	1989
Daniel L. Swift, Rockford	1990

Peer Review Committee

John H. Steinkamp, Belvidere, *Chairman*	1990
David K. Deets, Dixon	1989
Edward D. Maglietta, Freeport	1989
Daniel L. Swift, Rockford	1990

ISMS TRUSTEE DISTRICTS



1987 Officers of County Medical Societies

County	*Members*	*President*	*Secretary*
Adams	Members: 94-Dist. 6 Maxine Boyer, Ex. Sec., 2039 Sunnybrook, P.O. Box 767, Quincy 62306	Richard Ravel 1415 Vermont St., Quincy 62301	Richard L. Newman 1225 Broadway, Quincy 62301
Alexander-Pulaski	Members: 5-Dist. 9	Crisostomo Lozada 2020 Cedar St., Cairo 62914	Gemo Y. Wong 2020 Cedar St., Cairo 62914
Bond	Members: 10-Dist. 7	Boyd A. McCracken, Jr. Health Care Drive, Rural Rt. 3, Box 40 Greenville 62246	Charles R. Daisy 308 W. College Ave., Greenville 62246
Boone	Members: 24-Dist. 12	Alan W. Sherman 1221 E. State St., Rockford 61108	Jaime F. Sanz 303 Andrews Dr., Belvidere 61008
Bureau	Members: 35-Dist. 2	Rakesh K. Garg 600 E. First, Spring Valley 61362	Edwin L. Johnson 115 Walnut, Box 157, Tiskilwa 61368
Carroll	Members: 6-Dist. 12	Benjamin Sy 333 Chicago Ave., Savanna 61074	Lemuel B. Hussey 333 Chicago Ave., Savanna 61074
Champaign	Members: 304-Dist. 8 Larry Booth, Ex. Sec., 11½ E. University Ave., Suite A Champaign 61820	Arthur R. Traugott 1107 Elliot Dr., Urbana 61801	David W. Morse Carle Clinic Association 602 W. University, Urbana 61801
Christian	Members: 21-Dist. 7	Helmut W. Hess 213 S. Locust St., Pana 62557	Ignacio Del Valle 311 S. Main, Taylorville 62568
Clark	Members: 5-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Steven Macke Cork Medical Center, Marshall 62441
Clay	Members: 4-Dist. 7	Fred W. Cycholl 102 W. 3rd St., Flora 62839	Nashaat H. Naam 318 S. Walnut, Clay City 62824
Clinton	Members: 18-Dist. 7	William K. Drake P.O. Box 415, Highland 62249	James A. Kirby Box 87, 989 Clinton, Breese 62230
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County	*Members*	*President*	*Secretary*
Crawford	Members: 15-Dist. 8	Michael W. Elliott 1002 N. Allen, Robinson 62454	W.B. Schmidt 408 S. Cross St., Robinson 62454
DeKalb	Members: 66-Dist. 12	William S. Kenshol 10 Mechanic St., Sandwich 60548	Richard A. Lane Dekalb Clinic 217 Franklin St., DeKalb 60115
DeWitt	Members: 10-Dist. 5	John W. Veirs 219 E. Main, P.O. Box 348 Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas	Members: 12-Dist. 8	Grant A. Jones 106 S. Ash, Arthur 61911	Robert N. Arrol 126 S. Locust, Arcola 61910
DuPage	Members: 834-Dist. 11 Lillian Widmer, Ex. Admin., 800 Roosevelt Road, Building B-Suite 300, Glen Ellyn 60137	Robert E. Fitzgerald 498 Hillside, Glen Ellyn 60137	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar	Members: 13-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham	Members: 26-Dist. 7		P. D. Nayak 407 W. Virginia Ave., Effingham 62401
Fayette	Members: 12-Dist. 7	Donald H. Rames 1029 N. Eighth St., Vandalia 62471	Hans Rollinger 1003 N. Eighth St., Vandalia 62471
Ford	Members: 12-Dist. 2	Ross N. Hutchison 126 E. 9th St., Gibson City 60936	David J. Hagan 214 N. Sangamon, Gibson City 60936
Franklin	Members: 26-Dist. 9	Saeed Khan Benton Medical Center, P.O. Box 639 Benton 62812	Bob G. Thompson The Professional Building 309 W. St. Louis St., W. Frankfort 62896
Fulton	Members: 40-Dist. 4	Jaime Cercone 710 N. Main St., Lewistown 61542	Linda Forestier 175 S. Main, Canton 61520
Gallatin	Members: 1-Dist. 9	John E. Doyle Rte 1, Ridgway 62979	John E. Doyle Rte 1, Ridgway 62979
Greene	Members: 10-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid Fillanger Memorial Clinic 712 S. College, Greenfield 62044
Hancock	Members: 9-Dist. 4	Vasant Pawar 216 Parkway Drive, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
Henderson	Members: 2-Dist. 4	Silvino C. Lindo, Jr. P.O. Box 248, Biggsville 61418	Martha L. McCusker Henderson County Rural Health Ctr. Rt. 164 E., P.O. Box 118 Oquawka 61469
Henry-Stark	Members: 31-Dist. 4	William K. Ebert 123 W. Court St., Toulon 61483	Randall L. Mullin 648 N. Chicago St. Geneseo 61254

County	*Members*	*President*	*Secretary*
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Jackson	Members: 129-Dist. 9 Sue Davis 404 W. Main, Carbondale 62901	William K. Harryman Carbondale Clinic 2601 W. Main St., Carbondale 62901	Roger D. Jones 207 W. Jackson St., Carbondale 62901
Jasper	Members: 1-Dist. 8	Monico Low P.O. Box 377, 609 S. Van Buren St., Newton 62448	Monico Low P.O. Box 377, 609 S. Van Buren St., Newton 62448
Jefferson-Hamilton	Members 46-Dist. 9	Alan Froehling 413 E. Main St., Mt. Vernon 62864	Kenneth A. Peart #1 Doctors Park Rd., Mt. Vernon 62864
Jersey-Calhoun	Members: 15-Dist. 6	Roger A. Schroeder P.O. Box 7 Jerseyville 62052	Bernard M. Baalman Medical Center, Hardin 62047
Jo Daviess	Members: 9-Dist. 12	Wilbur E. Johnson 219 Summit St., Galena 61036	David R. Smith 219 Summit St., Galena 61036
Kane	Members: 348-Dist. 1 H. Michael Wild, Ex. Dir., 355 First St., Batavia 60510	Robert K. Dean 123 South St., #240, Geneva 60134	Fred V. Kemp 1870 W. Galena Blvd., Aurora 60506
Kankakee	Members: 111-Dist. 2 Joan Moody, Exec. Sec., St. Mary's Hosp., 500 W. Court St., Kankakee 60901	Nicholas M. Slimack P.O. Box 2149 Kankakee 60901	Charles F. Lind St. Mary's Hospital 500 W. Court St., Kankakee 60901
Kendall	Members: 5-Dist. 2	John P. Cullinan 126 S. Main, Oswego 60543	Joseph L. Daw 126 S. Main, Oswego 60543
Knox	Members: 82-Dist. 4 Jane Gau, Exec. Sec., Galesburg Cottage Hospital 695 N. Kellogg, Galesburg 61401	Agha B. Babanoury 765 N. Kellogg, #309, Galesburg 61401	Robert H. Wagner Medical Arts Clinic Grove & Seminary, Galesburg 61401
Lake	Members: 576-Dist. 1 Jane R. Stein, Exec. Dir., 1117 S. Milwaukee, Forum One—Suite 13, Libertyville 60048	Adam H. Romeiser, Jr. 800 Westmoreland Rd. #103, Lake Forest 60045	Raza M. Khan 1616 Grand Ave., #105, Waukegan 60085
LaSalle	Members: 115-Dist. 2	James Gottemoller 301 S. Bloomington St., Streator 61364	Caner Celeboglu 104 6th St., P.O. Box 828, Streator 61364
Lawrence	Members: 11-Dist. 8 Georgia T. Tabler Executive Secretary Lawrence County Mem. Hosp. West State St. Lawrenceville, 62439	Gary Carr R.R. #4, Box 1, Lawrenceville 62439	Frank E. Martin 542 N. Main St., Bridgeport 62417
Lee	Members: 27-Dist. 12	Mary Ann Polascik McNichols Clinic, Ltd., 120 S. Hennepin Ave., Dixon 61021	Tiam H. Lie 425 River Bluff Rd., Dixon 61021
Livingston	Members: 28-Dist. 2	Ram S. Pankaj 325 E. Timber, Bldg. A, Pontiac 61764	Dalisay Bello-Manabat 612 E. Water, Pontiac 61764

County	*Members*	*President*	*Secretary*
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Macon	Members: 182-Dist. 7 Mary J. Bretz, Ex. Sec., 1800 E. Lake Shore Dr., Decatur 62521	Dale Jones Medical Arts Center #350 1900 E. Lake Shore Drive, Decatur 62521	Boyd Nelson 2300 N. Edward St., Decatur 62526
Macoupin	Members: 23-Dist. 6	Kamal K. Chopra 130 W. Center, Girard 62640	Robert G. England 1115 Morgan, Carlinville 62626
Madison	Members: 239-Dist. 6	Raymond K. Weber 3 Junction Dr., Edwardsville 62025	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion	Members: 56-Dist. 7	Shanmuam Lakshmanan 111 E. Rogers, Salem 62881	Mary K. Markle 1201 E. Broadway, Centralia 62801
Marshall-Putnam	Members: 2-Dist. 2	Don Gallagher P.O. Box 583 Granville 61326	Joe W. Cannon 202 South Main, Lacon 61540
Mason	Members: 5-Dist. 5	Henry W. Maxfield 715 E. Chestnut, Mason City 62664	Henry W. Maxfield 715 E. Chestnut, Mason City 62664
Massac	Members: 5-Dist. 9	Bharat K. Patel Rt. 2 P.O. Box 191, Metropolis 62960	Randy Oliver 600 Ferry St., Metropolis 62960
McDonough	Members: 37-Dist. 4	David W. Reem 505 E. Grant Macomb 61455	Richard C. Watson 525 E. Grant, Macomb 61455
McHenry	Members: 101-Dist. 1 Phyllis Kalemba 330 W. Terra Cotta Crystal Lake 60014	Edward Wilt, Jr. 330 W. Terra Cotta, Crystal Lake 60014	Parmod Narang 4318-JW Crystal Lake Rd., McHenry 60050
McLean	Members: 159-Dist. 5 Madge Williams, Exec. Adm., 1236 E. Empire St., Bloomington 61701	Wilbert G. Thielemann 207 Prospect, Bloomington 61701	Lawrence A. Raines 2304 E. Oakland, Bloomington 61701
Mercer	Members: 5-Dist. 4	Dennis D. Palmer 409 N.W. 4th St., Aledo 61231	Dennis D. Palmer 409 N.W. 4th St., Aledo 61231
Monroe	Members: 10-Dist. 10	Edilberto F. Maglasang 109 W. Legion, Columbia 62236	William H. Winkler 650 N. Market, P.O. Box 142 Waterloo 62298
Montgomery	Members: 26-Dist. 5	Barbara A. Mulch 1250 E. Tremont, Hillsboro 62049	Roger Wujek 1225 E. Union Ave., Litchfield 62056
Morgan-Scott	Members: 46-Dist. 6	Joseph Kozma 1440 W. Walnut, Jacksonville 62650	Richard E. Fox 1606 W. Lafayette, Jacksonville 62650
Moultrie	Members: 3-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Phillip Best 14 N. Washington, Sullivan 61951

County	*Members*	*President*	*Secretary*
Ogle	Members: 16-Dist. 12	Lloyd T. Koritz 324 Lincoln Hwy., Rochelle 61068	Russell Zack P.O. Box 418, 915 Caron Rd. Rochelle 61068
Peoria	Members: 508-Dist. 4 M. John Hanni, Jr., Ex. V.P., 427 1st Nat'l Bank Bldg., Suite 205 Peoria 61602	Thomas G. Cassidy 515 N.E. Glen Oak, Suite 205, Peoria 61603	Ben J. Dolin 120 N.E. Glen Oak, Peoria 61603
Perry	Members: 14-Dist. 10	Raghuveer M. Kudva, P.O. Box 425 DuQuoin 62832	John G. Fozard 206 N. Main, Pickneyville 62274
Piatt	Members: 7-Dist. 7	George G. Green 1109A N. State, Monticello 61856	William E. Mundt 499 N. Buchanan, Monticello 61856
Pike	Members: 10-Dist. 6	Thomas C. Bunting RR 1, Box 315B, Pittsfield 62363	Ronald Johnson 112 W. Jefferson Pittsfield 62363
Randolph	Members: 24-Dist. 10	John R. Beck 840 State, Chester 62233	Teera Pittayathikhun 628 Cypress, Sparta 62286
Richland	Members: 26-Dist. 8	Fred B. Goslin Weber Medical Clinic, 1200 N. East St., Olney 62450	Chandra Varadachari Richland Memorial Hospital 800 E. Locust, Olney 62450
Rock Island	Members: 215-Dist. 4 James A. Koch, Ex. V.P. 608 Kahl Bldg., 326 W. Third St., Davenport, Iowa 52801	James F. Duesman 1520 7th St., #602, Moline 61265	Patrick C. Cunningham 2701 17th St., Rock Island 61201
St. Clair	Members: 276-Dist. 10 Adrienne Noubarian, Ex. Dir., 6400 W. Main, Suite 3L, Belleville 62223	Dennis J. Stanczyk 301 W. Lincoln, #57, Belleville 62223	Cosme R. Cagas 6024 W. Main St., Belleville 62223
Saline-Pope-Hardin	Members: 25-Dist. 9	Elliot O. Partridge Doctor's Clinic Ltd. 1201 Pine St., Eldorado 62930	Steven D. Knight Doctor's Clinic Ltd. 1201 Pine St., Eldorado 62930
Sangamon	Members: 526-Dist. 5 Sharon L. Bell, Exec. Dir., 611 N. 6th St. Lower Level Springfield 62702	Elvin G. Zook SIU School of Medicine P.O. Box 3926, Springfield 62708	Victor H. Lary St. Johns Hosp., 800 E. Carpenter, Springfield 62769
Schuyler	Members: 10-Dist. 4	Russell R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher 110 N. Congress, Rushville 62681
Shelby	Members: 11-Dist. 7	Vernon R. Klinefelter Shelby County Medical Ctr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
Stephenson	Members: 73-Dist. 12	Vinod K. Wadhwa Freeport Clinic 1036 W. Stephenson, Freeport 61032	John L. Lutz Freeport Clinic 1036 W. Stephenson St., Freeport 61032
Tazewell	Members: 60-Dist. 4 Colleen Ingersoll, Exec. Sec., P.O. Box 778, Pekin 61554	Min Woo Lee Pekin Memorial Hosp., 14th and Court St., Pekin 61554	M.A. Sheikh 2900 W. Kingston Ct., Peoria 61604

County	*Members*	*President*	*Secretary*
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Vermilion	Members: 104-Dist. 8	Raja Sadiq 3009 Golf Terr., Danville 61832	Michael Lomax 917 N. Walnut, Danville 61832
Wabash	Members: 6-Dist. 9	Donna Gambel 1001 Market St., Mt. Carmel 62863	Donna Gambel 1001 Market St., Mt. Carmel 62863
Warren	Members: 15-Dist. 4	James W. Marshall 319 N. Main St., Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington	Members: 5-Dist. 10	Thomas J. Coy 113 W. St. Louis St. P.O. Box 307, Nashville 62263	Ralph H. Kelley 113 W. St. Louis St. P.O. Box 307, Nashville 62263
Wayne	Members: 12-Dist. 9	Michael A. Blood Cisne Clinic, Box 248, Cisne 62823	Merle H. Muller Cisne Clinic P.O. Box 248, Cisne 62823
White	Members: 7-Dist. 9	Phillip D. Boren Doctor's Clinic South Plum St., Carmi 62821	Morris A. McCall Doctor's Clinic South Plum St. Carmi 62821
Whiteside	Members: 55-Dist. 12 Karen Schouweiler Community General Hosp., 1601 1st Ave., Sterling 61081	Bradley Meek 350 Washington St., Prophetstown 61277	Sterling Baumwell 202 W. Miller Rd., Sterling 61081
Will-Grundy	Members: 274-Dist. 2 Ronald W. Batozech, Ex. Sec., 3033 W. Jefferson, Suite 220, Joliet 60435	Joseph P. Karcavich 217 E. 127th St., Lemont 60439	William D. Woodward 3233 W. Oakwood Dr., Joliet 60435
Williamson	Members: 41-Dist. 9	George B. Murphy, Jr. Marion Memorial Hospital, 917 W. Main St., Marion 62959	Herman Lyle, Jr. 1608 W. Main St., Marion 62959
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No Organized County Society: Cass-Brown, Edwards, Johnson, Menard

Joint County Societies: Alexander-Pulaski; Coles-Cumberland; Henry-Stark; Jefferson-Hamilton; Jersey-Calhoun; Marshall-Putnam; Morgan-Scott; Saline-Pope-Hardin; Will-Grundy.

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Second Vice-President—*Vacant*
Secretary-Treasurer—Harold L. Jensen, Ingalls Memorial Hospital, Office of Medical Affairs, 1 Ingalls Dr., Harvey 60426
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Vice Speaker—Joan E. Cummings, 181 Hines VA Hospital, Room C-124D, Bldg. 1, Hines 60141

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Ulrich F. Danckers, 1040 Monroe Ave., River Forest 60305 1988
Robert C. Hamilton, 711 W. North Ave., Chicago 60610 1989
M. Anita Johnson, 8620 W. 93rd Place, Hickory Hills 60457 1990
William J. Marshall, 2601 Lincoln Hwy., Olympia Fields 60461 1988
Adriano S. Olivar, St. James Hosp., Dept. of Pathology, Chicago Rd. & Lincoln Hwy., Chicago Heights 60411 1990
Robert M. Vanecko, 6200 N. Kilpatrick Ave., Chicago 60646 1990
4th District—Lorris M. Bowers, 214 NE Glen Oak, Suite 600, Peoria 61603 1988
5th District—Michael C. Snyder, St. John's Hosp., Dept. of Radiology, 800 E. Carpenter St., Springfield 62702 1989
6th District—George T. Wilkins, Jr., #1 Glen Ed Prof. Park, Edwardsville 62025 1990
7th District—Alfred J. Kiessel, St. Mary's Hospital, Dept. of Pathology, 1800 East Lake Shore Dr., Decatur 62521 1988
8th District—Arthur R. Traugott, 1107 Eliot Dr., Urbana 61801 1989
9th District—Phillip D. Boren, Doctor's Clinic, South Plum St., Carmi 62821 1990
10th District—Ronald G. Welch, 333 S. Illinois, Suite B, Belleville 62220 1990
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12th District—Raymond E. Hoffmann, 1030 Highview Ave., Rockford 61107 1989
Trustee-At-Large—Jere E. Freidheim, Mercy Hospital and Medical Center, Stevenson at King Dr., Chicago 60616 1988

AMA Delegation Chairman, *Ex-Officio*—Robert C. Hamilton, 711 W. North Ave., Chicago 60610
ISMIE Board of Governors Chairman, *Ex-Officio*—Fred Z. White, P.O. Box 279, 525 Sweetbriar, Chillicothe 61523
ISMIS Board of Directors Chairman, *Ex-Officio*—Robert C. Hamilton, 711 W. North Ave., Chicago 60610

Ex-Officio Members of the House without the Right to Vote

Past Presidents

Herschel Browns* 1981
Edward W. Cannady* 1970
Newton DuPuy* 1968
David S. Fox* 1979
Jere E. Freidheim* 1987
Robert C. Hamilton 1985
J. M. Ingalls 1976
Charles J. Jannings, III 1972
Frank J. Jirka, Jr.* 1973
Robert P. Johnson* 1984
Fredric D. Lake* 1975
Morgan M. Meyer 1986
Willard C. Scrivner* 1974
P. John Seward* 1980
Joseph H. Skom* 1977
Leo P. A. Sweeney* 1953
Fred Z. White* 1982
Cyril C. Wiggishoff* 1983
George T. Wilkins, Jr. 1978

**Also a past trustee or councilor*

Past Speakers

Edward W. Cannady, Belleville 1965-1968
Maurice M. Hoeltgen, Chicago 1968-1970
Paul W. Sunderland, Gibson City 1970-1973
Andrew J. Brislen, Chicago 1973-1975
James A. McDonald, Geneva 1975-1977
Cyril C. Wiggishoff, Chicago 1977-1979
Robert P. Johnson, Springfield 1979-1981
Clifton L. Reeder, Wilmette 1981-1983
Julian W. Buser, Belleville 1983-1985
Lawrence L. Hirsch, Northbrook 1985-1987

Ex-Officio Members of the House without the Right to Vote

Past Trustees

Richard H. Blankshain, Oak Park, Trustee of the 3rd District
George H. Burke, Rock Island, Trustee of the 4th District
Julian W. Buser, Belleville, Trustee of the 10th District
Joan E. Cummings, Hines, Trustee of the 3rd District
Raymond DesRosiers, Chicago, Trustee of the 3rd District
Herbert Dexheimer, Belleville, Trustee of the 10th District
Alfred Faber, Northbrook, Trustee of the 3rd District
Robert T. Fox, Chicago, Trustee of the 3rd District
Jere E. Freidheim, Chicago, Trustee of the 3rd District
Morris T. Friedell, Chicago, Trustee of the 3rd District
Lee N. Hamm, Lincoln, Trustee of the 5th District
Robert R. Hartman, Jacksonville, Trustee of the 6th District
Henrietta Herbolsheimer, Chicago, Trustee of the 3rd District
Lawrence L. Hirsch, Northbrook, Trustee of the 3rd District
Eugene Hoban, Chicago, Trustee of the 3rd District
Kenneth Hurst, Naperville, Trustee of the 11th District
Harold L. Jensen, Flossmoor, Trustee of the 3rd District
Eugene P. Johnson, Casey, Trustee of the 8th District
James Laidlaw, Champaign, Trustee of the 8th District
Harold J. Lasky, Chicago, Trustee of the 3rd District
Ted LeBoy, Chicago, Trustee of the 3rd District
A. Edward Livingston, Bloomington, Trustee of the 5th District
Paul F. Mahon, Springfield, Trustee of the 5th District
Boyd E. McCracken, Greenville, Trustee of the 7th District
Thomas P. Meirink, Belleville, Trustee of the 10th District
Joseph R. O'Donnell, Glen Ellyn, Trustee of the 11th District
Joseph Perez, Rockford, Trustee of the 12th District
Arthur R. Peterson, Chicago, Trustee of the 3rd District
Mather Pfeiffenberger, Alton, Trustee of the 6th District
Pedro A. Poma, Melrose Park, Trustee of the 3rd District
Robert L. Prentice, Springfield, Trustee of the 5th District
Ralph N. Redmond, Sterling, Trustee of the 2nd District
Clifton L. Reeder, Wilmette, Trustee of the 3rd District
John J. Ring, Mundelein, Trustee of the 1st District
Richard N. Rovner, Chicago, Trustee of the 3rd District
Joseph C. Sherrick, Chicago, Trustee of the 3rd District
Harry A. Springer, Evanston, Trustee of the 3rd District
Darrell H. Trumpe, Springfield, Trustee of the 5th District
Warren D. Tuttle, Harrisburg, Trustee of the 9th District
Frederick E. Weiss, Harvey, Trustee of the 3rd District
Charles K. Wells, Mt. Vernon, Trustee of the 9th District
Cyril C. Wiggishoff, Chicago, Trustee of the 3rd District
Herman Wing, Chicago, Trustee of the 3rd District

ISMS Delegation to the AMA

Delegation Chairman: Robert C. Hamilton/Secretary: George T. Wilkins, Jr.

Delegates

To serve from Jan. 1, 1986 to Dec. 31, 1987
(Elected April 27, 1985)

Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Robert C. Hamilton, Chicago
Harold L. Jensen, Flossmoor
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana
Ronald G. Welch, Belleville*

To serve from Jan. 1, 1987 to Dec. 31, 1988
(Elected April 5, 1986)

James H. Andersen, Oak Brook
Audley F. Connor, Jr., Chicago
Joan E. Cummings, Hines***
Lawrence L. Hirsch, Northbrook
Joseph R. O'Donnell, Glen Ellyn
Pedro A. Poma, Melrose Park
Richard Quinones, Chicago
P. John Seward, Rockford
Robert M. Vanecko, Chicago
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

To serve from Jan. 1, 1988 to Dec. 31, 1989
(Elected April 12, 1987)

Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Robert C. Hamilton, Chicago
Harold L. Jensen, Flossmoor
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana
Ronald G. Welch, Belleville

Alternates

To serve from Jan. 1, 1986 to Dec. 31, 1987
(Elected April 27, 1985)

Randall T. Bellows, Chicago
Albino Bismonte, Waukegan
Joan E. Cummings, Chicago
Ulrich F. Danckers, River Forest
Earl E. Fredrick, Jr., Chicago
A. Beaumont Johnson, Elgin
Carlos B. Lara, Pittsfield
Robert M. Reardon, Bloomington*
Joseph H. Skom, Chicago
M. LeRoy Sprang, Evanston**
Donald K. Rokosch, Danville**

To serve from Jan. 1, 1987 to Dec. 31, 1988
(Elected April 5, 1986)

Juanito S. Bartolome, Jr., Chicago
Scott Bernstein, Urbana****
H. Constance Bonbrest, Chicago
Chester C. Danehower, Jr., Peoria***
Manuel O. Guerrero, Moline
Henrietta Herbolsheimer, Chicago
Alfred J. Kiessel, Decatur
Eugene B. Loftin, Elgin****
William J. Marshall, Olympia Fields
Joseph B. Perez, Rockford

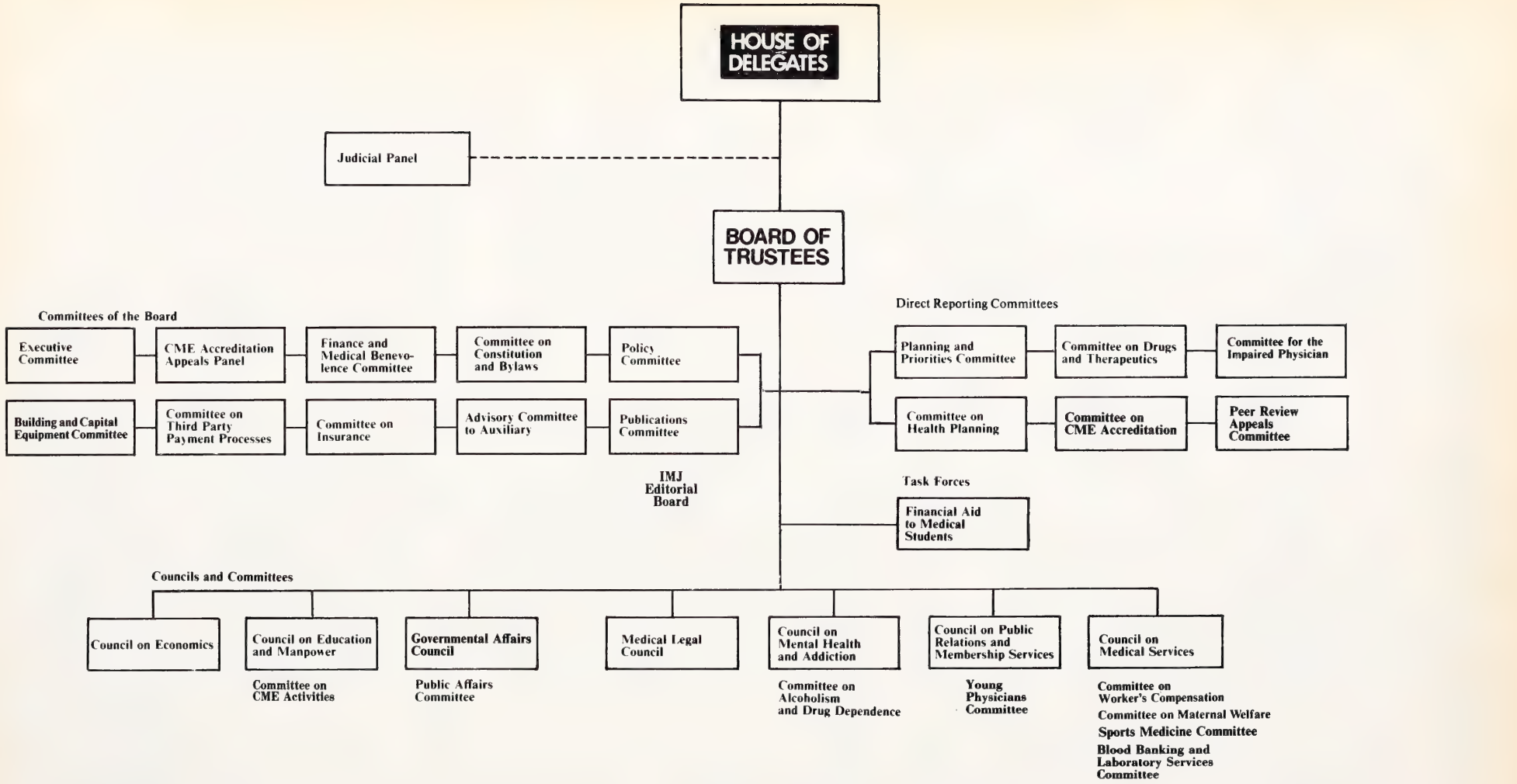
To serve from Jan. 1, 1988 to Dec. 31, 1989
(Elected April 12, 1987)

Randall T. Bellows, Chicago
Albino Bismonte, Waukegan
Ulrich F. Danckers, River Forest
Earl E. Fredrick, Jr., Chicago
A. Beaumont Johnson, Elgin
Silvana Menendez, Belleville
Robert M. Reardon, Bloomington
Donald K. Rokosch, Danville
Joseph H. Skom, Chicago
M. LeRoy Sprang, Evanston

**Elected April 5, 1986 to complete unexpired term until Dec. 31, 1987*
***Elected April 12, 1987 to complete unexpired term until Dec. 31, 1987*
****Elected to 20th position April 12, 1987 to serve immediately and until Dec. 31, 1988*
*****Elected April 12, 1987 to complete unexpired term until Dec. 31, 1988*

Honorary Members

Frank J. Jirka, Jr., Barrington Hills; John J. Ring, Mundelein



Organizations Directly Related to ISMS

- Illinois State Medical Benevolent Fund, Inc.
- Illinois State Medical Insurance Services, Inc.
- Illinois State Medical Inter-Insurance Exchange
- ISMS Auxiliary
- ISMS Educational and Scientific Foundation
- ISMS Hospital Medical Staff Section
- Medical Student Section
- Resident Physician Section

Organizations with formal ISMS Representation

- Swanberg Foundation
- Ill. Society of Medical Assistants
- Ill. Interagency Council on Smoking and Disease
- Ill. Medical Records Assn.
- Illinois Cancer Council
- Citizen's Committee on an Illinois Program to Control High Blood Pressure
- U. S. Pharmacopaeia
- Student Loan Fund Board, ISMS/IAA

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board committees. Some free standing committees may report directly to the Board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the Board, as do representatives to various other agencies. The president, speaker of the House, and chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

COUNCIL ON ECONOMICS

Fred Z. White, Chillicothe, *Chairman*
James A. Bull, Silvis
Patrick E. Ebenhoeh, Chicago
Peter E. Friedell, Chicago
Robert C. Goff, Morris
Arvind K. Goyal, Itasca
Larry R. Jones, Harrisburg
William E. Kobler, Rockford
Joseph Murphy, Chicago
Ronald F. Pokornowski, Carol Stream
Norman J. Scheibling, Springfield
Gerald E. Silverstein, Chicago

Consultants:
Phillip D. Boren, Carmi
Pedro A. Poma, Melrose Park
Robert M. Vanecko, Chicago

Resident Representative
Ronald W. McLawhon, Palos Hills

Student Representative
K. Gregory Lucchesi, Chicago

Auxiliary Representative
Norma Kiessel, Decatur

Responsibilities and Purposes:

The Council on Economics considers issues that are of direct and immediate economic concern to the practice of medicine in Illinois. The Council is interested in effective practice management and the economic impact of governmental health care activities and policies, private health care initiatives, alternative health care delivery systems and the activities of the various utilization review agencies (*i.e.,* PRO, Foundations for Medical Care and private preadmission review initiatives). The Council analyzes the impact of these programs, both existing and proposed, and reports its recommendations to the Board of Trustees.

COUNCIL ON EDUCATION AND MANPOWER

Boyd McCracken, Sr., Greenville, *Chairman*
Francois Alouf, Chicago
Bruce C. Becker, Chicago
Michael A. Blood, Cisne
Dean R. Bordeaux, Peoria
Daniel G. Cunningham, Chicago
Morris A. Kugler, Belleville
Philip A. Lobo, Arlington Heights
Mitchell L. Rhodes, Chicago
Stephen Schubert, Mendota

Consultants
H. Constance Bonbrest, Chicago
Raymond A. Dieter, Jr., Glen Ellyn
Jere Freidheim, Chicago
William Marshall, Olympia Fields

Resident Representative
Geoffrey Coleman, Chicago

Student Representative
Dipali V. Apte, Champaign

Auxiliary Representative
Laura Hays, Kankakee

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for allied health personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R & E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

Committees:

CME Activities

COMMITTEE ON CME ACTIVITIES

Dean R. Bordeaux, Peoria, *Chairman*
Mohan C. Airan, Woodridge
Robert A. Behmer, Rockford
Robert L. Bertrand, Rockford
Joseph L. Daddino, Barrington
Michael G. Feinzimer, Highland Park
Peter Fried, Lisle
Ronald L. Johnson, Pittsfield

Responsibilities and Purposes:

The Committee on CME Activities serves as the planning and approval body for the Society's continuing education activities. The committee is responsible for identifying educational needs of Illinois physicians, assisting ISMS councils and committees (as directed by the Board or if requested by a committee) in their educational activities, applying for and maintaining ACCME accreditation for ISMS programs, producing programs and materials for medical education directors, and evaluating the application and effectiveness of ISMS CME programs and products in meeting the needs of Illinois physicians.

GOVERNMENTAL AFFAIRS COUNCIL

Terry Mason, Chicago, *Chairman*
Frank O. Becker, Monee
Albino Bismonte, Gurnee
Edward Ference, Springfield
Laurence J. Gott, Hoffman Estates
Alec B. Hood, McLeansboro
J. M. Ingalls, Paris
Eugene B. Loftin, Elgin
Paul F. Mahon, Springfield
Joseph Purpura, Lake Forest
Albert W. Ray, Jr., Joliet
Biswamay Ray, Oak Brook
Erlo Roth, Hinsdale
Thomas C. Schrepfer, Urbana
Paul R. Stanley, Decatur
William Tansey, Downers Grove

Consultants
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago
Raymond E. Hoffmann, Rockford
Ronald G. Welch, Belleville

Auxiliary Representative
Mrs. Alan (Pam) Taylor, Danville

Student Representative
Lisa Dynan-Dobbertien, Chicago

Resident Representative
Mark Dobbertien, Chicago

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Cooperate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs

PUBLIC AFFAIRS COMMITTEE

Paul F. Mahon, Springfield, *Chairman*
Norman R. Brill, Olympia Fields
John Golden, Silvis
Thomas M. Iannucci, Olympia Fields
Harold Lasky, Chicago
Ronald K. McGregor, Decatur
Charles A. Neumann, Downers Grove
Jerome Weiskopf, Rockford

Auxiliary Representative
Mrs. Wesley (Sherry) Betsill, Springfield

Consultant
George T. Wilkins, Jr., M.D., Edwardsville

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

MEDICAL LEGAL COUNCIL

Geoffrey Bland, Springfield, *Chairman*
Susan Balter, River Forest
Philip H. Dennis, E. St. Louis
Alan R. Hirsch, Chicago
Robert Libman, Chicago
George B. Murphy, Marion
H. Larry Penning, Decatur
M. Leroy Sprang, Evanston
Warren H. Staley, Chicago
Michael Victor, Barrington

Consultants
James H. Andersen, Oak Brook
David Littman, Highland Park
Adriano Olivar, Chicago Heights
Arthur Traugott, Urbana

Resident Representative
Jonathon Kahn, J.D., Chicago

Student Representative
Steven Rubin, Springfield

Auxiliary Representative
Lynn Kassel, Joliet

Responsibilities and Purposes:

The Council cooperates with all organizations interested in medico-legal problems and educates members of the profession in such affairs. In addition, the Council is concerned with standards of practice, licensure and quackery.

This Council maintains liaison with the Illinois State Bar Association and cooperates with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Evaluator Panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

COUNCIL ON MEDICAL SERVICES

James L. McGee, Decatur, *Chairman*
James P. Ahstrom, Downers Grove
E. Richard Blonsky, Chicago
Anthony Galloway, Belleville
H. Bates Noble, Barrington
Terry R. Noonan, Urbana
Marvin A. Rosner, Chicago
Nunilo Rubio, Chicago
Richard J. Sassetti, Chicago
Stephen H. Sheldon, Chicago
Peter J. Soto, Belleville
Joseph D. Winterhalter, Jacksonville

CONSULTANTS:
Lorris Bowers, Peoria
Audley Connor, Chicago
Harold Jensen, Harvey
Michael Snyder, Springfield

STUDENT REPRESENTATIVE
Lynn Malanfant, Rockford

RESIDENT REPRESENTATIVE
Joel M. Press, Chicago

AUXILIARY REPRESENTATIVE
Lori Winterhalter, Jacksonville

IDPH REPRESENTATIVE
Director Bernard Turnock, M.D., Springfield

Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, laboratory services and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workers' compensation, sports medicine, and penal health care services.

Committees:

Blood Banking and Laboratory Services
Maternal Welfare
Sports Medicine
Workers' Compensation

COMMITTEE ON BLOOD BANKING AND LABORATORY SERVICES

Peter J. Soto, Belleville, *Chairman*
Ahmed M. Anees, Chicago
Robert E. Carlovsky, Rockford
John G. Dietrich, Springfield
Harold Rothenberg, Chicago
Richard J. Sassetti, Chicago
Marshall Short, Chicago
R. Bruce Wellman, Urbana
Thomas Wiltbank, Peoria

CONSULTANT:
Adriano Oliver, Chicago Heights

Responsibilities and Purposes:

The Committee considers issues and programs pertaining to medical laboratories, blood banking, and related areas affecting the practice of medicine in Illinois; handles matters brought to its attention by the Council on Medical Services; reviews matters related to standards of practice and provides guidance on improving patient care provided via medical laboratories, blood banks, and related entities; works with state agencies on matters relating to medical laboratories, blood banks, and related areas; and oversees ISMS direction to support the provision of blood transfusion services that meet the needs of the patients throughout Illinois, via coordinating activities and discussions with blood banks.

COMMITTEE ON MATERNAL WELFARE

DISTRICT MEMBERS AND ALTERNATES
(alternates in italics)

1. Jack M. Miller, Aurora
2. Carl P. Mattioda, Streator
Leo Wrona, Joliet
3. Marvin A. Rosner, Chicago, *Chairman*
Linda Holt, Wilmette
4. Robert Westefer, Peoria
Jeffrey N. Maurus, Moline
5. Robert C. Kaufman, Springfield
Thomas M. O'Hern, Springfield
6. Lemuel G. Villanueva, Jacksonville
Alan Skirball, Granite City
7. Herbert W. Thompson, Decatur
William Van Bergan, Effingham
8. Juan F. Rojas, Danville
9. Cynthia Fraed, Harrisburg
10. Steven Mathus, Belleville
Rosel Calong, O'Fallon
11. A. William Schafer, Hinsdale
Thomas R. Eckman, Downers Grove
12. John E. Tillis, Rockford

CONSULTANTS:
Robert R. Hartman, Jacksonville
John Louis, Lake Forest
Augusta Webster, Chicago
Ed Ryan, Palos Park
Bernard Turnock, IDPH, Springfield
Diana Mertens, Springfield
Richard Gelfand, Evanston

Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

SPORTS MEDICINE COMMITTEE

H. Bates Noble, Barrington, *Chairman*
Daniel Adair, Springfield
Craig Dean, Libertyville
Henry J. Dold, Arlington Heights
Richard J. Dominguez, Carol Stream
Jeffrey Gilles, Rockford
James A. Hill, Chicago
Robert M. Jarrett, Jr., Rockford
Dennis J. Stanczyk, Belleville
Edward Winslow, Chicago

CONSULTANT:
Robert C. Hamilton, Chicago

Responsibilities and Purposes:

The committee conducts programs aimed at improving the recognition and treatment of athletic-related injury and disease; advises junior and senior high school coaches and trainers; works with other groups and organizations involved in sports medicine activities; and provides overall direction to the ISMS Physician Games.

COMMITTEE ON WORKERS' COMPENSATION

E. Richard Blonsky, Chicago, *Chairman*
James LaFata, Springfield
Dominick S. Renga, Chicago
Alberto E. Rodriguez, Oak Park
James W. Ryan, Des Plaines
Jay V. Subbarao, Hines

Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the workers' compensation system in Illinois.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Thomas Minogue, Urbana, *Chairman*
Fern E. Asma, Chicago
Andrew Griffin, Chicago
Earl Loschen, Springfield
P.S. Sarma, Chicago
Robert S. Study, Chicago
Thomas T. Tourlentes, Galesburg
Jeffrey A. Wolfson, Aurora
James D. Wright, Joliet

Consultants:
Lorris Bowers, Peoria
Audley Connor, Chicago
Robert Reardon, Bloomington

Student Representative
Robert Stephen Callaghan, Chicago

Auxiliary Representative
Pat Spadoni, Willow Brook

IDMH/DD Representative
Edward Page-El, M.D., Chicago

Responsibilities and Purposes:

This council serves as a source of information on mental health matters for ISMS. The council cooperates with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse. It is also concerned with reviewing legislation and regulations related to these fields and provides direction for the ISMS Substance Abuse Education program.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Andrew Griffin, Chicago, *Chairman*
Sam Gaines, Springfield
Ronald Kirschner, Glenview
David Spencer, Springfield

Consultants:
Roalda J. Alderman, Dept. of Alcoholism and Substance Abuse
Daniel Behnke, Dept. of Alcoholism and Substance Abuse

IMGMA Representative
Barbara Thomas, Chicago

Auxiliary Representative
Darlene Stevenson, Quincy

Responsibilities and Purposes:

The committee works closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Jane Jackman, Springfield, *Chairman*
Giles R. Locke, Decatur
Silvana Y. Menendez, Belleville
Morgan M. Meyer, Lombard
Stanley G. Rousonelos, Joliet
William B. Spriegel, Evanston
John M. Sultan, Glencoe
Lloyd E. Thompson, East St. Louis
Virgil L. Williams, Chicago

Consultant Trustees
Raymond E. Hoffmann, Rockford
M. Anita Johnson, Hickory Hills
Harry A. Springer, Evanston

Consultant County Executives
John Hanni, Peoria
Fred Schwartz, Chicago
Lillian Widmer, Glen Ellyn
Madge Williams, Bloomington

Resident Representative
Sanford Sherman, Chicago

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance relationships between the media, public and members of the medical profession; and to retain and recruit members in the Society.

Committee

Young Physicians

COMMITTEE ON YOUNG PHYSICIANS

John M. Sultan, Glencoe, *Chairman*
Michael Davidson, Oak Park
Linda Holt, Evanston
Tim Kisabeth, Alton
Alan M. Roman, Flossmoor
Michael R. Silver, Oak Park

Resident Representative
Judith L. Peters, Springfield

Responsibilities and Purposes:

The Committee addresses the unique, specific and pressing needs of young physicians.

Committees of the Board of Trustees

ADVISORY COMMITTEE TO ISMS AUXILIARY

Jere E. Freidheim, Chicago, *Chairman*
Edward J. Fesco, LaSalle
Alfred J. Kiessel, Decatur

Responsibilities and Purposes:

The Committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The Committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members. It shall also monitor the services provided by ISMS to the Auxiliary.

BUILDING AND CAPITAL EQUIPMENT COMMITTEE

Alfred J. Kiessel, Decatur, *Chairman*
Alfred J. Clementi, Arlington Heights
Edward J. Fesco, LaSalle
Harold L. Jensen, Harvey
Harry A. Springer, Evanston
Ronald G. Welch, Belleville

Responsibilities and Purposes:

The Committee shall review and monitor activities pertaining to the building and capital equipment.

COMMITTEE ON CONSTITUTION AND BYLAWS

Robert M. Reardon, Bloomington, *Chairman*
Joan E. Cummings, Hines
David B. Littman, Highland Park
Michael C. Snyder, Springfield
Robert M. Vanecko, Chicago

Responsibilities and Purposes:

The Committee on Constitution and Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

CME ACCREDITATION APPEALS PANEL

Ulrich F. Danckers, River Forest, *Chairman*
H. Constance Bonbrest, Chicago
Audley F. Connor, Jr., Chicago
Raymond A. Dieter, Jr., Glen Ellyn
Ross N. Hutchison, Gibson City
Pedro A. Poma, Melrose Park
Ronald G. Welch, Belleville

Responsibilities and Purposes:

In the event the Committee on CME Accreditation makes a non-accreditation decision to an Illinois CME sponsor, the sponsor may make a formal appeal to this hearing committee, which, in turn, will make a formal recommendation to the ISMS Board of Trustees on the sponsor's application.

EXECUTIVE COMMITTEE

Alfred J. Kiessel, Decatur, *Chairman*
Alfred J. Clementi, Arlington Heights
Edward J. Fesco, LaSalle
Jere E. Freidheim, Chicago
Harold L. Jensen, Harvey
Pedro A. Poma, Melrose Park
Harry A. Springer, Evanston
Ronald G. Welch, Belleville

Ex Officio (without vote)
Robert C. Hamilton, Chicago
Robert M. Reardon, Bloomington
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, the chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the chairman of the Board of Directors of the Illinois State Medical Insurance Services, Inc., and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE AND MEDICAL BENEVOLENCE COMMITTEE

Ronald G. Welch, Belleville, *Chairman*
Raymond E. Hoffmann, Rockford
Harold L. Jensen, Harvey
Harry A. Springer, Evanston

Auxiliary Representative
Mrs. Gayle Dustman, Bloomington

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the Society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

COMMITTEE ON INSURANCE

Phillip D. Boren, Carmi
Harold L. Jensen, Harvey
M. Anita Johnson, Hickory Hills
Michael C. Snyder, Springfield
Ronald G. Welch, Belleville

Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. Current policies and new types of insurance programs are evaluated in order to recommend changes that may benefit society members. The Committee works closely with the program's administrator, Corroon & Black, Inc.

POLICY COMMITTEE

Joan E. Cummings, Hines, *Chairman*
Lorris M. Bowers, Peoria
David B. Littman, Highland Park

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.

PUBLICATIONS COMMITTEE

William J. Marshall, Olympia Fields, *Chairman*
Joan E. Cummings, Hines
Raymond A. Dieter, Jr., Glen Ellyn
Raymond E. Hoffmann, Rockford
George T. Wilkins, Jr., Edwardsville

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, shall review all new accounts prior to acceptance and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

Larry C. Gunn, Hinsdale
Eugene J. Rogers, Chicago
Constantine S. Soter, Northbrook
David E. Trachtenbarg, Peoria
Donald D. VanFossan, Springfield
Edward A. Wolpert, Chicago

THIRD PARTY PAYMENT PROCESSES COMMITTEE

Arthur R. Traugott, Urbana, *Chairman*
James H. Andersen, Oak Brook
Alfred J. Clementi, Arlington Hts.
Audley F. Connor, Jr., Chicago
David B. Littman, Highland Park
Adriano S. Olivar, Chicago

ISIM Representative
Donald L. Casey, Oak Park

Responsibilities and Purposes:

The Committee on Third Party Payment Processes is a committee of the Board of Trustees. Its primary responsibility is to interact with the appropriate governmental and private third party reimbursement agencies on matters that require a role at the Board level. It monitors the activities of the Illinois Department of Public Aid, the Medicare program in Illinois, the CHAMPUS program in Illinois, Blue Cross/Blue Shield, other private insurers and other appropriate agencies whose problems have a significant impact on physician reimbursement. This committee reviews the policies of these organizations and makes appropriate recommendations to the Board of Trustees.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON CME ACCREDITATION

Donald Pochyly, Chicago, *Chairman*
Maruti S. Bhorade, Elmhurst
Ernesto B. Eusebio, Springfield
Julius S. Newman, Aurora
Anthony Sapienza, Northbrook
Simon Zivin, Lincolnwood

CONSULTANTS:
H. Constance Bonbrest, Chicago
Ross N. Hutchison, Gibson City
David Littman, Highland Park

Responsibilities and Purposes:

The committee adopts necessary procedural rules and prescribes forms to be used in the conduct of CME accreditation. It reviews applications and survey team reports for intrastate CME sponsors, and makes decisions on the granting of initial accreditation and continuation of accredited status.

Accreditation Activities

ISMS is approved by the Accreditation Council on Continuing Medical Education to accredit intrastate CME sponsors. An integral part of the program is the site visit, used to gather materials, document and verify that the applicant has met the essentials for accreditation.

Physicians throughout the state, including members of the Board of Trustees, councils, committees and medical educators, function as survey team members to gather the necessary information, interview appropriate individuals and observe local CME activities. The Survey Site Team then makes recommendations to the ISMS Committee on CME Accreditation, which makes the final determinations for approval by the ISMS Board of Trustees.

Accredited Illinois CME Sponsors as of September 1, 1987

Alexian Brothers Medical Center, Elk Grove Village
Augustana Hospital and Health Care Center, Chicago
Belleville Hospital Association for CME (Memorial Hospital, St. Elizabeth Hospital), Belleville
Carle Foundation Hospital, Urbana
Central Community Hospital, Chicago
Central DuPage Hospital, Winfield
Christ Hospital, Oak Lawn
Condell Memorial Hospital, Libertyville
Copley-Mercy CME Consortium, Aurora
Edgewater Hospital, Chicago
Elgin Mental Health Center, Elgin
Elmhurst Memorial Hospital, Elmhurst
Forest Hospital, Des Plaines
Franciscan Medical Center, Rock Island
Glendale Heights Community Hospital, Glendale Heights
Good Samaritan Hospital, Downers Grove
Gottlieb Memorial Hospital, Melrose Park
Grant Hospital, Chicago
Henry Horner Children's Center, Chicago
Highland Park Hospital, Highland Park
Hinsdale Sanitarium & Hospital, Hinsdale
Holy Cross Hospital, Chicago
Humana Hospital, Hoffman Estates
Hyde Park Community Hospital, Chicago
Illinois Masonic Medical Center, Chicago
Ingalls Memorial Hospital, Harvey
Institute for Psychoanalysis, Chicago
Kishwaukee Community Health Center, DeKalb
Louis A. Weiss Memorial Hospital, Chicago
Lutheran General Hospital, Park Ridge
MacNeal Memorial Hospital, Berwyn
Martha Washington Hospital, Chicago
Mary Thompson Hospital, Chicago
Mercy Hospital & Medical Center, Chicago
The Methodist Medical Center of Illinois, Peoria
Mount Sinai Hospital Medical Center, Chicago
Northwest Hospital, Chicago
Northwest Community Hospital, Arlington Heights
Norwegian-American Hospital, Chicago
Oak Forest Hospital, Oak Forest
Oak Park Hospital, Oak Park
Prairie Cardiovascular Center, Springfield
Provident Medical Center, Chicago
Ravenswood Hospital Medical Center, Chicago
Resurrection Hospital, Chicago
Riveredge Hospital, Forest Park
Riverside Hospital, Kankakee
Rockford Memorial Hospital, Rockford
St. Anne's Hospital, Chicago
St. Anthonys Hospital, Chicago
St. Anthony Hospital Medical Center, Rockford
St. Elizabeth's Hospital, Chicago
St. Elizabeth Hospital, Danville
St. Francis Hospital, Evanston
Saint Francis Hospital Medical Center, Peoria
St. James Hospital, Chicago Heights
St. Joseph Hospital, Chicago
St. Joseph Hospital, Elgin
St. Mary's Hospital, Kankakee
St. Mary's Hospital, Streator
St. Mary of Nazareth Hospital, Chicago
St. Therese Hospital, Waukegan
Sherman Hospital, Elgin
Shriner's Hospital for Crippled Children, Chicago
Silver Cross Hospital, Joliet
Skokie Valley Community Hospital, Skokie
Springfield Clinic, Springfield
Swedish American Hospital, Rockford
Swedish Covenant Hospital, Chicago
Westlake Community Hospital, Melrose Park
West Suburban Hospital, Oak Park

Accreditation Site Surveyors

The following individuals participate in accreditation activities by serving as site surveyors (all are physicians unless otherwise indicated):

Philip D. Anderson, M.D., Ph.D.
Anthony L. Barbato
Lloyd Barr, Ph.D.
Robert L. Bertrand
Ben B. Blivaiss, Ph.D.
H. Constance Bonbrest
Ernst Chester Bone
Dean R. Bordeaux, M.D., M.A.
Bradford W. Claxton, M.Ed.
Alfred J. Clementi
Joan E. Cummings
Joseph L. Daddino
Richard E. Dukes
Sherman Elias
Peter O. Fried
Linda K. Gunzburger, Ph.D.
Robert R. Hartman
Terry F. Hatch
Henri Havdala
Thomas O. Henderson, Ph.D.
Lawrence L. Hirsch
Eugene T. Hoban
Raymond Hoffmann
John M. Holland
Kathryn S. Huss
Ross N. Hutchison
William L. Jackson
Harold L. Jensen
Frank J. Jirka, Jr.
Eugene P. Johnson
Marten M. Kernis, Ph.D.
Alfred J. Kiessel
Howard B. Levy
Paul A. Maxwell, Jr.
Boyd E. McCracken, Sr.
Morgan M. Meyer
Joseph R. O'Donnell
Thomas G. Pearson, Ed.D
Joseph B. Perez
Ward E. Perrin
Joseph C. Sherrick
Robert C. Stepto
Francis H. Straus, II
Jacob R. Suker
L.W. Tanner
Sheldon S. Waldstein
Fred Z. White, M.D., M.A.
George T. Wilkins, Jr.
Roger A. Wujek
William H. Young, Ed.D.

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
Lawrence L. Hirsch, Northbrook
Theodore M. Kanellakes, Joliet
Armand Littman, Evanston
Allan L. Lorincz, Chicago
Patrick R. Staunton, Oak Park

Consultants:
Joan E. Cummings, Hines
David B. Littman, Highland Park

IDPA Representative:
Dawn Atkins-Gottrich, Springfield

IPHA Representative:
Sam Enloe, Jr., R.Ph., Decatur

Responsibilities and Purposes:

The committee meets periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to list new products in the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Comments or suggestions made by the membership regarding drug products also are reviewed by the committee.

COMMITTEE ON HEALTH PLANNING

Henrietta Herbolsheimer, Chicago, *Chairman*
Martin E. Bruetman, Palos Heights
Robert M. Flanigan, Barrington
Albert J. Novotny, Peoria
Orlan W. Pflasterer, Coulterville
Mark E. Swislow, Lincolnwood
Constantine J. Tatooles, Evanston

Consultants:
M. Anita Johnson, Chicago
David B. Littman, Highland Park
Robert M. Vanecko, Chicago

Auxiliary Representative:
Nancy Hoffmann, Rockford

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Health Facilities Planning Board and local planning agencies. The Committee also monitors health care coalitions in Illinois and reports to the Board on coalition activities.

COMMITTEE FOR THE IMPAIRED PHYSICIAN

L. Michael Newman, Evanston, *Chairman*
Daniel Angres, Lombard
Ira M. Brent, Decatur
Violet Eggert, Chicago
Thomas T. Flynn, Mt. Vernon
Charles Frazer, Jr., St. Louis
Lee Gladstone, Chicago
Thomas M. Iannucci, Chicago Heights
Thomas Krizek, Chicago
James Leonard, Champaign
Richard L. Newman, Quincy
Homer Parkhill, Pontiac
Eduardo Ricaurte, Moline
Reinhold Schuller, Kankakee
Donald Sellers, Des Plaines
Craig Showalter, Chicago
Herbert Trace, Evanston
William J. Weigel, Aurora
James West, Rolling Meadows

Resident Representative:
Debra Klamen, Chicago

Consultants:
Ulrich F. Danckers, Melrose Park
Michael C. Snyder, Springfield

Responsibilities and Purposes:

The Committee for the Impaired Physician consists of physicians who provide assistance to impaired physicians and those concerned about them for problems related to alcohol or drug dependence, physical disabilities, mental or emotional disturbances. The Committee provides information, sponsors educational programs, offers counseling, conducts interventions, provides monitoring and serves as the recovering physician's advocate. All activities are provided in a confidential and professional manner.

PEER REVIEW APPEALS COMMITTEE

Boone Brackett, Oak Park, *Chairman*
Henri S. Havdala, Chicago
John P. McGee, Glenview
Donald Pearson, Springfield
James Russell, Downers Grove

Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relations issues. The committee is the state society's liaison to local peer review committees and monitors review activities around the state.

PLANNING AND PRIORITIES COMMITTEE

Harry A. Springer, Evanston, *Chairman*
Randall T. Bellows, Chicago
Laurence Gott, Hoffman Estates
Raymond Hoffmann, Rockford
Harold Jensen, Harvey
David B. Littman, Highland Park
Ronald G. Welch, Belleville

Responsibilities and Purposes:

The president-elect shall serve as the chairman of the Committee on Planning and Priorities. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the president-elect in the formation of his objectives for accomplishment during his term as president.

TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

Fred Z. White, Chillicothe, *Chairman*
Jere E. Freidheim, Chicago
Morgan M. Meyer, Lombard
Karl W. Scheribel, Arlington Hts.

Student Representative
Roderick L. Matticks

Auxiliary Representative
Norma Kiessel, Decatur

AMA-ERF Chairman
Evelyn Perlmutter, Moline

Responsibilities and Purposes:

The Task Force on Financial Aid to Medical Students shall be responsible for developing and maintaining a student loan program through the Educational & Scientific Foundation to assist Illinois medical students in meeting financial obligations of an undergraduate medical school program. In particular, this Task Force shall explore ways and means of raising funds for the development of a student loan program and, through the ISMS Educational and Scientific Foundation, establish guidelines and administration for such a program.

Direct Reporting Committees of the House of Delegates

JUDICIAL PANEL COMMITTEE

	Term Expires
Frank B. Norbury, Jacksonville, *Chairman*	1988
Daniel G. Cunningham, Riverside	1992
Arthur R. Fischer, Berwyn	1989
Jack L. Gibbs, Canton	1991
Robert H. Lund, Rockford	1990

Responsibilities and Purposes:

The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack L. Gibbs, Canton, *Chairman*
David Dunn, Urbana
Randall Mullin, Geneseo
John Arnold, Bushnell (alternate)

Responsibilities and Purposes:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

ISMS REPRESENTATIVES TO OTHER GROUPS

Swanberg Foundation, Quincy
Robert R. Hartman, Jacksonville

Liaison to Ill. Soc. of Med. Assts.
Robert R. Hartman, Jacksonville

Ill. Interagency Coun. on Smoking and Disease
Charles L. Swarts, Oak Park

Illinois Medical Records Assoc.
Clifton Reeder, Wilmette

Illinois Cancer Council
Peter Friedell, Chicago

Citizens Committee for an Illinois Program to Control High Blood Pressure
David Berkson, Chicago

U.S. Pharmacopaeia
Vincent Costanzo, Chicago, *Delegate*
Joseph Skom, Chicago, *Alternate*

ISMS SERVICES

Members of the Illinois State Medical Society benefit from a wide range of services, programs, and publications. These are developed in response to official actions and policies of the House of Delegates and implemented through the Board of Trustees. The headquarters staff has been structured to respond to the directives of the House and the Board and develops and coordinates activities to provide these services. Following is a brief description of the divisional structuring, organization and services of the Society and the headquarters office.

EXECUTIVE OFFICE

Mr. Alexander R. Lerner is Executive Administrator of the Society. The Executive Administrator is responsible for the implementation of established policy, fiscal, budgetary and personnel matters. In this position, the Executive Administrator:

- provides liaison with the Board of Trustees and implements their actions
- is responsible for support and staffing of the House of Delegates
- evaluates legal inquiries for appropriate referral to counsel
- has final authority for management team program planning and implementation
- provides guidance to officers, trustees, committee chairmen and county society officers
- directs activity and organization of staff personnel
- serves as secretary-treasurer for the Illinois State Medical Insurance Services, Inc.

Society programs, issues and activities are coordinated administratively through delegation of managerial authority.

ADMINISTRATION

The Deputy Administrator, Administration, directs and manages activities of the Divisions of Specialty Society Services and Administrative Records. Additionally, direct staff support is provided through the Deputy Administrator for the House of Delegates, Board of Trustees, Executive Committee, Policy Committee, Constitution and Bylaws Committee, the Educational and Scientific Foundation, the Medical Student Section and the Resident Physicians Section. Overall provision of services of staff are coordinated through the Deputy Administrator. The Deputy Administrator reports directly to the Executive Administrator and assumes additional responsibility at the direction of the Executive Administrator.

Administrative Records

The Division of Administrative Records is charged with responsibility for maintaining the listing of official actions and positions taken by ISMS' House of Delegates and Board of Trustees. The minutes and official transcriptions are maintained by this Division. In addition, records of all appointments and nominations are kept, as well as any other official documents.

Services to Specialty Societies

Administrative services are provided to specialty societies and affiliated groups on a cost-allocated basis by the Division of Specialty Societies. These include office management, meeting arrangements, membership promotion and record maintenance, newsletter publishing, coordination of committee work, dues collection and accounting services.

COMMUNICATIONS

Under direction of the Assistant Administrator, Communications, the membership, marketing, public relations, publications and office and meeting services activities are coordinated. Staff in these areas:

- provide information on a broad range of issues that affect physicians in their practices;
- provide information to the media and public on the position of ISMS on important medical issues;
- provide consultation and coordination to other ISMS divisions in the area of membership mailings, and distribution of membership and public information;
- provide information and services to hospital medical staffs;
- retain, recruit, promote and process membership in organized medicine at the county, state and AMA levels;
- educate physicians on the professional liability climate in general, and on the value of the Exchange in particular; and
- provide information and coordinate programs for the ISMIS Loss Prevention Committee.
- provide staff support to the ISMS Hospital Medical Staff Section; and
- provide meeting, travel and office services to members and staff.

Meeting and Office Services

A number of programs and services are provided to Society members or sponsored

for their benefit. These include the 50-Year-Club, physician recruitment, meeting services and travel programs.

- The 50-Year-Club consists of physicians who graduated from medical school more than 50 years ago. An annual luncheon gives these members an opportunity to renew friendships.
- ISMS meeting services include provision of services for assemblies of the House of Delegates and Board of Trustees. Councils and committees meet in the headquarters office.
- Society-sponsored travel programs enable members to enjoy luxury cruises and tours. Qualified tour agencies are screened for professional, non-regimented trips.

ISMS conducts several programs for new physicians and those seeking either a medical education or an opportunity to practice in Illinois.

- The Physician Recruitment Program seeks to link communities in need of a physician with those seeking practice opportunities.

Office services includes building services for staff and physician meetings, mail, printing and supply services for the Society. Centralized purchasing is also under the office service function.

Publications

Staff of the Division of Publications work to provide information to the ISMS membership through various publications. Services include promotional design and layout, editorial and creative work for such publications as:

- The *Illinois Medical Journal* which is published monthly to keep members aware of clinical, economic, legal, and political events;
- Additional brochures and reports developed as needed.

Society staff members produce several publications for the Illinois State Medical Inter-Insurance Exchange, including:

- *Exchange Commentary* which serves as ISMIE's main method of communicating with its policyholders;
- *Antidote* which is published jointly with the ISMIS Loss Prevention Committee and discusses case studies designed to help physicians avoid the situations that can lead to malpractice suits; and
- The ISMIE *Annual Report* which presents end-of-year financial data and operating statistics to Exchange policyholders.

ISMS staff assists specialty societies and other affiliate groups in producing their newsletters and other publications. Assistance also is provided to the ISMS Auxiliary in the publication of *Pulse of the ISMS Auxiliary*.

Activities of the Division are directed by the Society's Publications Committee and the *IMJ* Editorial Board. Additional publication production services are provided for subsidiary organizations.

Public Relations

The ISMS Public Relations Division provides information to news media representatives and the public on health care issues. Building the visibility and image of Illinois' medical profession is the division's overall goal. Its activities include regular, frequent development of:

- news releases and related media information voicing ISMS public policy views;
- speeches for use by Illinois physicians in making presentations to a variety of public audiences;
- "white papers," viewpoint essays and brochures on key health care issues;
- public service announcements for broadcast by Illinois radio and television stations; and
- public information resource materials for use by county medical societies.

On a daily basis, the Public Relations Division handles all ISMS media requests and monitors coverage of health care-related topics by Illinois media outlets. Staff is also available to conduct spokesperson training workshops for those physicians speaking out on behalf of ISMS. The division provides services and programming for the Council on Public Relations and Membership Services.

FINANCE

Financial Management

Financial Management services are conducted under policies established by the Board of Trustees and Finance Committee. These activities include:

- financial reporting;
- maintaining financial records for receipts and disbursements;
- budgeting;
- monitoring investments;
- securing assets; and
- maintaining liaison with the various auditing firms.

GOVERNMENTAL AFFAIRS

The Division of Governmental Affairs, under direction of the Assistant Administrator for Governmental Affairs, provides staff services for the Governmental Affairs Council, Public Affairs Committee, IMPAC, Field Services and liaison to various governmental agencies. The Society's legislative program is conducted under direction of the Governmental Affairs Council. All state and national health legislation is monitored. Society staff forward bills to physician members with pertinent expertise for review and comment. Legislative representatives express the ISMS position to legislators, while also continually monitoring amendments to bills of interest to the medical profession. The Division also coordinates physician testimony before legislative committees.

Additional input and citizen involvement are developed through the Key Contact Program, public affairs activity and *On the Legislative Scene*.

- The Key Contact Program is a network of physicians or spouses who are relatives, friends or campaign supporters of Illinois legislators, who advise legislators on health legislation.
- Public Affairs activity includes sponsorship of speakers at Society meetings and liaison with government agencies. It encourages grassroots involvement in the political process. Also, the Division coordinates activities of the Illinois State Medical Society Political Action Committee.
- *On the Legislative Scene* which is distributed on request to ISMS members during the General Assembly session to offer a status report on pending legislation of importance to Illinois physicians.

Field Services

Staff in this area:

- provide assistance and information to ISMS members on a broad range

of issues by working with district trustees, county medical society leaders and executives, hospital medical staff leaders and ISMIE Network Representatives;
- coordinate the ISMS President's Tour, in which the president visits county medical society meetings and local media to discuss Society views and activities;
- publish *Trustee Report,* a newsletter issued periodically which communicates important information on ISMS activities to local physician leaders; and
- promote and assist member activity to further ISMS legislative and governmental goals, including participation in IMPAC and the Key Contact program.

Staff services are provided through both the Chicago headquarters and the Springfield regional office.

HEALTH CARE FINANCE

Under the direction of the Assistant Administrator for Health Care Finance, the Division of Economics and the Division of Health Policy Research are involved in developing programs, policies, services and strategies to address the economic issues impacting the profession. Staff services are provided to the Council on Economics, the Committee on Third Party Payment Processes, the Committee on Health Planning and the Committee on Drugs and Therapeutics. Services are provided to members with questions or problems concerning health care economic issues and research.

Additionally, staff in this area maintain liaison with all appropriate professional associations and ancillary health economic organizations.

Staff in this area provide the following specific services:

Economics

- Medicaid, Medicare & CHAMPUS—Services are provided in representation of member interests of a policy nature. Liaison is provided with Illinois Department of Public Aid and the Medicare Part B carrier to assure that member concerns are represented when policy issues are considered. Specific assistance is provided for members with inquiries about third party payor policies.
- Health Planning—Actions of the State Planning Agency, Illinois Health Facilities Planning Board, and local planning agencies are closely monitored and Society positions expressed.
- Third Party Payor and Economic Activity—The Division is directly involved in liaison activities with insurance carriers and government bodies on all economic issues relating to the practice of medicine. The Division performs research, offers speakers and monitors the development of new reimbursement and health care delivery systems for the membership, *e.g.,* Diagnosis Related Groups (DRGs), Preferred Provider Organizations (PPOs), Utilization Review (Private and Peer Review Organizations [PROs]) and HMOs/IPAs.
- Drugs and Therapeutics—The Division provides staff assistance to the ISMS Committee on Drugs and Therapeutics, which reviews new drug products and makes recommendations to the Department concerning products for inclusion in the IDPA Drug Manual for Public Aid recipients.
- Office of Contractual Services—ISMS provides members a summary of the major terms and conditions of proposed PPO, HMO, and IPA contracts. The summary does not advise physicians to sign or not sign such contracts, nor is it intended to provide specific legal advice. However, the summary explains in detail the major terms and conditions of proposed PPO, HMO, and IPA contracts. Further, the impact of the contracting provisions on a physician's professional liability insurance is stressed. Members wishing such a review may submit two copies of the proposed contract and any documents incorporated by reference (*e.g.,* bylaws, UR agreements) to the ISMS offices.

Health Policy Research

- Health Data Systems—Governmental requirements for statistical information on health care and planning are monitored and commented upon.
- Research Development—Rules and regulations proposed by various state code departments (IDPA, IDPH, DOI, CMS) and federal agencies (HCFA) are researched, monitored and commented upon to ensure that ISMS concerns about policies and procedures that impact the practice of medicine are considered prior to implementation or adoption. The Division also reviews all pertinent Federal and Illinois registers, and proposed legislation for possible comment and action, provides statistical analyses for the leadership on health economic issues, serves as a vehicle for health economic research and maintains liaison within the federation concerning development of various strategies on health economic issues (RVS, statewide IPA, HMO).
- Cost Containment—The cost containment activities of various health care entities are monitored, such as the activities of the Illinois Hospital Services Procurement Advisory Board and the Illinois Health Care Cost Containment Council. Additionally, the Division provides Medical Society comment and input on the activities and programs of the Illinois Health Care Cost Containment Council.

MANAGEMENT SERVICES

The Management Services division is responsible for the direction of computer services, human resources and facility management.

Computer Services

As an integral part of management, electronic data processing capabilities are maintained to provide a cost-effective method to:

- maintain membership and policyholder records;
- provide central Society dues billings and collection for county medical societies;
- provide invoicing for professional liability premiums;
- maintain records and statistics on professional liability claims, policyholder files and other insurance related information;
- process financial records;
- provide word processing capabilities; and
- provide and maintain telecommunication abilities as needed throughout the organization.

Facility Management

This area is responsible for management of the physical premises occupied by the Society and maintains liaison with the building management. This includes building services necessary for staff and physician meetings.

Human Resources

The responsibilities of Human Resources include recruitment and staffing, employee benefits program, payroll, employee evaluation and review program, maintenance of all personnel files and the administration of all employee services.

PLANNING AND PROGRAM DEVELOPMENT

The responsibilities of the Associate Administrator for Planning and Program Development are designed to coordinate and execute a broad range of programs across divisional and organizational lines. These responsibilities include:

- provide staff support for the Planning & Priorities Committee and identification of major issues affecting physicians in their practice;
- develop programs that meet the informational needs of the physician membership and the public on the position of ISMS on important medical issues; and
- provide consultation and coordination to ISMS divisions and affiliated organizations on planning and program development.

In addition, the Associate Administrator for Planning and Program Development oversees and coordinates the activities of Educational and Medical Services, Professional Relations, and Sponsored Insurance Programs.

Educational and Medical Services

The Division of Educational and Medical Services is responsible for initiating, supporting, monitoring and implementing activities related to CME accreditation, alcohol and drug addiction, aging, emergency medical services, blood banking, licensure and accreditation of health care facilities, physician licensure and discipline, school and child health, medical education, medical-legal issues, sports medicine, public health, mental health, peer review, ethics, laboratory services and CME activities.

These responsibilities are carried out through the following activities:

- council and committee meetings, where physician members, and representatives of the medical students, residents and ISMS Auxiliary examine, debate and formulate ideas and recommendations for consideration by the ISMS Board of Trustees;
- development of educational materials and programs for the physician and his or her patients; and
- liaison activities with governmental, professional and lay organizations, to promote and defend ISMS policies, express concerns and educate others about issues important to physicians.

The Division of Educational and Medical Services also administers the following specialized programs:

- ISMS Physician Games, where physicians and spouses compete in athletic competitions;
- The Substance Abuse Education Program, funded by a grant from the Illinois Department of Alcoholism and Substance Abuse, which produces educational materials and seminars to assist physicians in recognizing and treating substance abuse in their patients;
- Maternal morbidity and mortality reviews, funded by a grant from the Department of Public Health;
- ISMS Student Loan Fund Programs, directed by the Task Force on Financial Aid to Medical Students, and funded by the contributions to the Educational and Scientific Foundation;
- Impaired Physician Program, which provides assistance to medical staffs, impaired physicians and their families in situations where alcohol, drugs, senility, disability or other problems prevent a physician from functioning;
- The Physician Support Group, which provides assistance to physician families in dealing with the confusion and stress accompanying involvement in a malpractice action; and
- The Physician Help Line, a confidential phone service, which connects troubled physicians and their families with the above mentioned services and resources.

These and other programs and services are available to ISMS members by calling or writing to the Division at the ISMS offices.

Professional Relations

The Division of Professional Relations provides staff support for the Illinois State Medical Society Auxiliary, the Resident Physicians Section, the Medical Student Section, the Ad Hoc Committee on Young Physicians and the ISMS Benevolence Fund. It also provides additional support to the Deputy Administrator, Administration, and the Associate Administrator for Planning & Program Development for the Illinois Delegation to AMA.

Sponsored Insurance Programs

ISMS sponsored insurance programs have merged with the Chicago Medical Society Trust. In the coming months, each ISMS and CMS program will be evaluated. The programs offered to ISMS members statewide will be the best programs possible. The following represents the current ISMS insurance programs.

Group Term Life Insurance

The group term life insurance program is underwritten by the North American Company for Life and Health Insurance. It offers:

- $25,000 to $1 million in level term life insurance
- a built-in waiver of premium
- availability to members, their spouses and employees under age 65
- coverage to $5,000 for members' children
- non-cancellable, guaranteed renewability to age 100
- conversion to permanent individual policy guaranteed to age 65.

Group Disability Income Protection Program

The group disability income protection program is underwritten by the Commercial Insurance Company. It provides:

- $500-$3,000/month for total disability
- coverage renewable to age 70
- benefit period options of lifetime accident and sickness
- payable (1) to age 65; (2) for seven years; (3) five year accident and sickness payable for 2 years
- available to members and authorized employees or insured members to age 55
- benefits payable regardless of other insurance
- no restrictive riders attached after issuance
- individual coverage cannot be terminated.

Professional Overhead Expense Plan

This plan is underwritten by the Hartford Accident and Indemnity Company and provides:

- $500-$5,000/month coverage
- office overhead expenses paid to maximum benefit selected beginning with 31st day of total disability
- benefits payable to 24 months regardless of other insurance
- accumulation benefit provided
- guaranteed issue for qualified new members under age 40 who apply within 60 days of effective date of membership
- available to all members under age

65 in full time practice
- rent, utilities, employee salaries and monthly *pro rata* of specified annual fixed expenses customary to the profession
- premiums deductible for individuals and partnerships under Revenue Ruling 55-264.

The plan does not cover personal income, salaries for other physicians, principal payments on debts, implements, pharmaceutical products and personal insurance premiums.

Group Major Medical

The group major medical plan is underwritten by Commercial Insurance Company. It provides that the insured select a calendar year deductible of $500, $1,000 or $2,000 which applies to each insured person. It will then pay 80% of reasonable and customary expenses such as:

- semi-private room in the hospital
- hospital supplies and services, physician services, anesthetists, diagnostic lab and x-ray, registered nurses, ambulance services, prescription drugs and medicines, physiotherapy, therapeutic equipment rentals, artificial limbs, oxygen and blood.

The plan has a maximum out-of-pocket expense of $4,000 plus deductible and pays up to a lifetime maximum of $1 million on health benefits. The plan is available to all members and qualified employees of insured members under age 55, and can be renewed up to age 65.

Medicare Supplement

The Medicare supplement plan is underwritten by the Hartford Accident & Indemnity Company. It covers charges for the following, incurred either as in-patient or out-patient:

- annual Medicare deductibles
- semi-private room and board
- diagnostic x-rays, lab tests, doctor's services, general nursing, drugs, anesthesia and many other hospital, medical and surgical services which are partially covered by Medicare.

The plan is available to members 65 and over and once members are enrolled, their spouses may be insured on reaching age 65. Eligible applicants are guaranteed acceptance subject to a pre-existing condition limitation.

Hospital Indemnity Plan

The Hartford Accident and Indemnity Company underwrites the ISMS-sponsored hospital indemnity plan. Available plans provide benefits of $27.50, $55.00, $110.00 or $165 per day of hospital confinement. Benefits are also:

- initiated with first day of confinement
- payable to 365 days for each cause of confinement
- automatically doubled for hospital stays due to cancer or confinement in an ICU for persons under age 65
- payable regardless of other insurance.

All members, their employees and families may participate. Acceptance of eligible applicants during special enrollment periods is guaranteed, subject to a pre-existing conditions limitation.

Workers' Compensation

Policies issued by the Casualty Reciprocal Exchange, a member of the Dodson Insurance Group, are administered under the Dodson Savings Plan. Specific aspects include the following:

- return declared at the end of each premium year on the basis of loss experience—savings are returned to policyholders
- rates standard and approved for class of employment
- savings paid as earned within approximately 90 days of policy expiration or on completion of payroll audits.

Accidental Death and Dismemberment

An accidental death and dismemberment plan is underwritten by the Hartford Accident & Indemnity Company. It provides coverage:

- for members, their spouses, children and employees
- a 24-hour business and pleasure coverage from $25,000 to $250,000
- renewable to age 70.

DIRECTORY OF MANAGEMENT STAFF PERSONNEL

The Illinois State Medical Society headquarters office is located at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602. The telephone number is (312) 782-1654. In addition, a Springfield office is maintained at 701 South Second Street, Springfield, Illinois 62704, telephone (217) 528-5609.

Below are the key staff identified by managerial areas in keeping with the above itemization of responsibilities. Following the name of the individual is a direct dial telephone number at the headquarters office. Any staff member can also be reached through the general information number (312) 782-1654.

EXECUTIVE OFFICE

Alexander R. Lerner, Executive Administrator 580-2412

ADMINISTRATION

Richard A. Ott, Deputy Administrator 580-2460
Rose Anne Christiansen, Director, Administrative Records 580-2470
Leslie Freeman, Director, Specialty Society Services 580-2480

COMMUNICATIONS

Linda Hudson, Assistant Administrator 580-2449
Suzanne W. Nelson, Deputy Assistant Administrator 580-2423
Elizabeth Duffy, Director, Meeting and Office Services 580-2472
Mariann Stephens, Director, Publications 580-2419
Susan Brooks, Policyholder Services Coordinator 580-2463

FINANCE

Director of Finance 580-2454

GOVERNMENTAL AFFAIRS

Jeffrey M. Holden, Assistant Administrator 580-2440
James Tierney, Deputy Assistant Administrator 580-2484
Gary Fitzgerald, Director, Field Services 580-2474
Daniel R. Nash, Field Representative 580-2411
Springfield Regional Office 217/528-5609

HEALTH CARE FINANCE

Robert K. Burger, Assistant Administrator 580-2462
Andrew Melczer, Director, Health Policy Research 580-2468
Ken Ryan, Director, Economics 580-2491

MANAGEMENT SERVICES

Diana Role, Senior Director, Management Services 580-2488
Carl Block, Director, Computer Services 580-2429

PLANNING AND PROGRAM DEVELOPMENT

Donald A. Udstuen, Associate Administrator 580-2418
Larry Boress, Director, Educational and Medical Services 580-2435
Cheryl Koos, Director, Professional Relations 580-2493
Violet Eggert, M.D., Medical Director, Impaired Physician Program .. 580-2445

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.
2) The collection, evaluation and dissemination of the results of research activities to the public.
3) The implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

Board of Directors

Jere E. Freidheim, Chicago, *Chairman*
Edward J. Fesco, LaSalle
Harold L. Jensen, Harvey
Alfred J. Kiessel, Decatur
Harry A. Springer, Evanston

Illinois Society of Medical Assistants

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society of Medical Assistants, an affiliate of AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending medical assistant programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are: travel courses, regional seminars, annual symposium, and personal development day. The annual three-day meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year. Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. For further information about this program contact the American Association of Medical Assistants, 20 North Wacker Drive, Chicago, Illinois 60606.

The president of the Illinois Society of Medical Assistants communicates via the "Executive Memo" (a monthly publication), with over 400 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on education topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the Association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for nonmembers. There are many other benefits available (*i.e.,* group insurance). AAMA holds five regional conferences (mini-conventions) at various sites in the country each year. A variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (Downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), West Cook (River Grove), Cook County South (Oak Forest), Aux Plaines (Oak Park); DeKalb (Sycamore); LaSalle; Macon (Decatur); McLean (Bloomington); Peoria; Rock Island; St. Clair (Belleville); Spoon River Valley (Canton) and Vermilion (Danville). Physicians in these areas are asked to encourage their medical assistants to join the Association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

If there are no Illinois Society of Medical Assistant chapters in your area, at-large memberships are available. Information on the formation of new chapters may be obtained from: Mary Lu Ostrowski, CMA, 1704 East Jackson Street, Bloomington, IL 61701 or Ehlma Garcia, CMA, EMT-A, 6134 South Tripp, Chicago, IL 60629.

Officers

President: Cheryl Hutchison, CMA, Granite City
President-Elect: Robin Bluestein, CMA-C, Chicago
Immediate Past President: Mary Lu Ostrowski, CMA, Bloomington
1st Vice President: Karen Schuerman, CMA, Bloomington
2nd Vice President: Rebecca Matteson, CMA, EMT-A, Canton
Recording Secretary: Marjorie Goldasich, Peru
Membership Secretary: Linda Harp, CMA, Granite City
Corresponding Secretary: Carolyn Ott, CMA, Danvers
Treasurer: Mary Frances Burton, Burnham
Speaker of the House: Betty Kronemeyer, CMA, Mascoutah
Vice Speaker of the House: A. Ruth Thompson, CMA, Decatur
Chairman, Board of Trustees: Janet Binkowski, RN, Dolton
Parliamentary Advisor: Synobia Payne, Chicago
Chaplain: Betty Burkhart, CMA, Belleville
Historian: Julie Stoffregen, CMA, Schaumburg
Chairman Physician Advisor: Bruce Steffens, M.D., Moline

Physician Advisors

Bruce Steffens, M.D., Moline, *Chairman*
Jack Chandler Berger, M.D., Chicago
Robert R. Hartman, M.D., Jacksonville, ISMS Liaison
T.R. Harwood, M.D., Chicago
Leslie Schwartz, M.D., Chicago
John L. Wright, M.D., Bloomington

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services, Inc., is an Illinois corporation, formed in March, 1976, the capital stock of which is owned by the Illinois State Medical Society. It currently acts as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Inter-Insurance Exchange was organized as an insurance reciprocal to provide comprehensive professional liability insurance for Illinois physicians. Membership in the Exchange is limited to members of the Illinois State Medical Society. The Exchange is chartered under the laws of Illinois and functions under the Illinois Insurance Code.

Insurance Services provides management and underwriting services required for operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement and by each member of the Exchange through application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business. Within these policy guidelines Insurance Services provides management by accepting or rejecting applications, determining the form of insurance policies, and handling and disposing of claims. Insurance Services is compensated by the Exchange on the basis of expense reimbursement.

As a wholly-owned subsidiary, ISMIS provides certain services through ISMS on a shared basis. These shared services are on a direct cost reimbursement basis. Insurance Services includes the Divisions of Underwriting, Claims, Management Services and Internal Audit. In addition, shared services support is provided by ISMS through the Divisions of Administration, Communications, Educational and Medical Services, Governmental Affairs, Finance and Accounting.

Offices of Illinois State Medical Insurance Services, Inc., are at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602; (312/782-2749).

Board of Directors

Robert C. Hamilton, M.D., Chicago, *Chairman*
Phillip D. Boren, M.D., Carmi
Alfred J. Clementi, M.D., Arlington Heights
Ulrich F. Danckers, M.D., River Forest
J.M. Ingalls, M.D., Paris
Alfred J. Kiessel, M.D., Decatur

Officers

Lawrence W. Deidrick, *President*
Alexander R. Lerner, *Secretary-Treasurer*

ISMS Auxiliary

The Illinois State Medical Society Auxiliary is a unique organization composed entirely of physicians' spouses who give their time and talents to promote health awareness, support medical legislation, and assist organized medicine. Auxiliary members raise funds for medical student loans, benevolence and for medical research and education through the American Medical Association Education and Research Foundation (AMA-ERF). Through AMA-ERF, we encourage a sense of giving and work for the support of quality medical education.

The Illinois State Medical Society Auxiliary had its inception in the parlor car of a speeding train in 1927. Dr. and Mrs. G. Henry Mundt were returning from the AMA meeting in Washington, D.C. and had learned of the existence of the AMAA and of 22 functioning state auxiliaries. Mrs. Mundt was persuaded to undertake the task of organizing an auxiliary in Illinois and to seek the approval of the Illinois State Medical Society's House of Delegates. On May 31, 1927, the ISMS House of Delegates endorsed the organization of an auxiliary in Illinois and urged the county societies to assist in promoting auxiliary membership.

The first formal meeting of the Auxiliary was held at the LeClaire Hotel in Moline on June 2, 1927, with 25 members present. In 1928, the organization became permanent. Today, we have a membership of over 2,700 and can look with pride on the Auxiliary accomplishments.

We have striven to educate the public on cost effective benefits of preventive healthcare through all segments of our comprehensive Shape Up for Life program. The Auxiliary has instituted a large number of successful community health programs (*e.g.*, vial of life, nutrition, physical fitness, stress management, child seat belt safety, immunization, substance abuse awareness, and teen suicide prevention). This year, we are focusing on membership, legislation, AIDS education and adolescent sexuality. We form coalitions with other community groups and network with organizations to gain their expertise and to lend ours.

The Auxiliary has been very active with legislation during the past year. We initiated the legislative internship program and have become quite knowledgeable in lobbying techniques. We also provide information on health-related legislation and are part of a legislative alert system. In an effort to have the Auxiliary expand activities in the area of support for the physician's family, we have formed a family advocacy program to address family problems unique to the medical profession, including impairment and malpractice.

Being part of a federation allows us to attend national meetings for leadership training and education. We encourage our county presidents-elect to take advantage of attending AMA Auxiliary Confluence in September and February. All members receive FACETS, a quarterly magazine to keep us abreast of other state activities and to keep us informed.

We communicate throughout Illinois with PULSE, which includes a message from the president.

Officers

President
Mrs. Wayne Kassel, Joliet
President-Elect
Mrs. Wesley Betsill, Springfield
1st Vice President
(Membership Coordinator)
Mrs. Alfred J. Kiessel, Decatur
2nd Vice-President
(Program & Project Bank Coordinator)
Mrs. Philip Hays, Kankakee
3rd Vice-President
(Health Projects Coordinator)
Mrs. Raymond Hoffmann, Rockford
Secretary
Mrs. Richard Newman, Quincy
Treasurer
Mrs. John McLean, Peoria

Directors

Mrs. Alex Spadoni, Willow Brook
Mrs. J. Anthony Dustman, Bloomington
Mrs. Jim Wilson, Princeton

Parliamentarian

Mrs. Harlan Failor, Champaign

District Councilors

1. Mrs. Vernon Guynn, St. Charles
2. Mrs. Donald Laasch, Joliet
3. Mrs. Silvio DelChicca, Chicago
4. Mrs. Chainaronk Limanon, Monmouth
5. Mrs. W.G. Thielemann, Carlock
6. Mrs. J.D. Winterhalter, Jacksonville
7. Mrs. G. Richard Locke, Decatur
8. Mrs. John Gapsis, Champaign
9. Mrs. James Chow, Mt. Vernon
10. Mrs. James Hull, Belleville
11. Mrs. Luis Cespedes, Oak Brook
12. Mrs. Gareth Eberle, Roscoe

Committee Chairmen

AMA-ERF
Mrs. Harold Perlmutter, East Moline
Archives
Mrs. Harlan Failor, Champaign
Benevolence
Mrs. J. Anthony Dustman, Bloomington
Boutique Coordinator
Mrs. Selig Hodes, Forreston

Bylaws
Mrs. Robert Webb, Edwardsville
Convention Co-Chairmen
Mrs. Alex Spadoni, Willow Brook
Mrs. William Sims, Joliet
Directory
Mrs. Alex Spadoni, Willow Brook
Editor
Mrs. Allan Minster, Lake Forest
Fall Conference
Mrs. Richard McCormick, Springfield
Finance
Mrs. Norman Taylor, East Alton
Health Projects Coordinator
Mrs. Raymond Hoffmann, Rockford
—Adolescent Sexuality
Mrs. Dwight Woiteshek, Shorewood
—Drugs & Alcohol
Mrs. Walter Stevenson, III, Quincy
—Family Advocacy
Mrs. Louis Tarsinos, Princeton
—Teen Suicide
Mrs. Stephen Schmidt, O'Fallon
Humanitarian Award
Mrs. Philip Hays, Kankakee
Legislation
Mrs. Alan Taylor, Danville
Long Range Planning
Mrs. Robert Reardon, Bloomington
Membership Coordinator
Mrs. Alfred J. Kiessel, Decatur
—Student/Resident
Mrs. Steve Greer, Springfield
—Retired
Mrs. Gamil Arida, Joliet
—Widows
Mrs. Earl Klaren, Libertyville
Members-At-Large
Mrs. James Geist, Kankakee
Program & Project Bank
Mrs. Philip Hays, Kankakee
Public Relations
Not yet known

Consultants

Cults
Mrs. George Olander, Lake Forest
Elderly
Mrs. Thomas Meirink, Belleville
International Health
Mrs. Sadiq Mohyuddin, Godfrey
Scrapbook
Mrs. August Martinucci, Joliet
Organ Donation
Mrs. James Monahan, Waukegan

Representatives to ISMS Councils & Committees

Finance & Medical Benevolence
Mrs. J. Anthony Dustman, Bloomington
Public Affairs
Mrs. Wesley Betsill, Springfield
Economics
Mrs. Alfred J. Kiessel, Decatur
Education & Manpower
Mrs. Philip Hays, Kankakee
Governmental Affairs
Mrs. Alan Taylor, Danville
Medical-Legal
Mrs. Wayne Kassel, Joliet
Medical Services
Mrs. J.D. Winterhalter, Jacksonville
Mental Health & Addiction
Mrs. Alex Spadoni, Willow Brook
Public Relations & Membership Services
Not yet known
Financial Aid to Medical Students
Mrs. Alfred J. Kiessel, Decatur

ISMS Hospital Medical Staff Section

Joseph L. Murphy, Chicago, *Chairman*
Silvana Y. Menendez, Belleville, *Vice-Chairman*
Thomas C. Malvar, Chicago, *Secretary*
George T. Wilkins, Jr., Edwardsville, *Treasurer*
Dennis M. Brown, Schaumburg, *Delegate*
Raymond A. Dieter, Jr., Glen Ellyn, *Alternate Delegate*
Albino T. Bismonte, Gurnee, *At-Large Member*
Ross N. Hutchison, Gibson City, *At-Large Member*
Jaroslav F. Neskodny, Berwyn, *At-Large Member*
Lawrence A. Stone, Park Ridge, *At-Large Member*

Responsibilities and Purposes

The Hospital Medical Staff Section shall provide representation of hospital medical staffs within the ISMS. The Section will also support the purposes of the ISMS, as stated in its Constitution. Membership in the Section consists of ISMS members who have been elected to represent their individual hospital medical staffs.

ISMS Medical Student Section

Jack Whitney, *Chairman*
Ken Herrmann, *Vice Chairman*
Donna Weber, *Secretary*
Jodie Rai, *Delegate*
Anthony Pivarunas, *Alternate Delegate*
Laura Fall, *MECO Co-Coordinator*

School Representatives

Chicago College of Osteopathic Medicine
Eric Kivisto, Delegate
Lisa Dynan-Dobbertien, Alternate
Chicago Medical School
Simone Tizes, Delegate
Laura Fall, Alternate
Loyola University
Michael Maguire, Delegate
Joseph Kokoszka, Alternate
Northwestern University Medical School
Hal Meltzer, Delegate
K. Gregory Lucchesi, Alternate
Rush Medical College
Brad Howeiler, Delegate
David Factor, Alternate
SIU School of Medicine
Rod Matticks, Delegate
Gregory Randolph, Alternate
University of Chicago
JoAnne Micale, Delegate
Mohamed Khan, Alternate
University of Illinois-Chicago
Howard Chodash, Delegate
Robert Wolski, Alternate
University of Illinois-Rockford
Guillermo Martinez-Torres, Delegate
Steve Demick, Alternate
University of Illinois-Peoria
Vacancy, Delegate
Vacancy, Alternate
University of Illinois-Champaign/Urbana
Michael Luttropp, Delegate
Navid Vahidi, Alternate

Council Representatives

Dipali Apte, Education & Manpower
Stephen Callaghan, Mental Health & Addiction
Lisa Dynan-Dobbertien, Governmental Affairs
K. Gregory Lucchesi, Economics
Lynn Malanfant, Medical Services
Keith Martin, Public Relations and Membership Services
Rod Matticks, Financial Aid to Medical Students
Steve Rubin, Medical-Legal

Responsibilities and Purposes

The purposes of the Medical Student Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Medical Student Section shall support the purposes of ISMS as stated in its Constitution. The Medical Student Section is composed of all student members of ISMS.

Illinois State Medical Society Political Action Committee (IMPAC)

The Illinois State Medical Society Political Action Committee will begin its 28th year as a leader in medical politics in 1988. IMPAC is a voluntary non-profit, unincorporated, permanent membership organization. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his/her spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U.S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U.S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Twenty North Michigan Avenue, Suite 700, Chicago 60602.

ISMS Resident Physicians Section

Tim Kuzel, *Acting Chairman*
Bruce Doblin, *Secretary/Editor*
Judith Peters, *Delegate*
Gail Herman, *Alternate Delegate*

Council Representatives

Geoffrey Coleman, Education & Manpower
Mark Dobbertien, Governmental Affairs
Jonathan Kahn, Medical-Legal
Debra Klamen, Committee on the Impaired Physician
Ronald W. McLawhon, Economics
Joel Press, Medical Services
Sanford Sherman, Public Relations & Membership Services

Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its Constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago College of Osteopathic Medicine
5200 S. Ellis Ave., Chicago, 60615
Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153
Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611
Rush Medical College
1725 W. Harrison St., Chicago, 60612
Southern Illinois University School of Medicine
801 N. Rutledge, P.O. Box 3926, Springfield, 62708
University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago, 60637
University of the Health Sciences/The Chicago Medical School
3333 Green Bay Road, North Chicago, 60064
University of Illinois College of Medicine*
Chicago Campus
1853 W. Polk Street, Chicago, 60612

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine and the School of Basic Medical Sciences (Urbana).

ALLIED HEALTH EDUCATION PROGRAMS

Accredited by the American Medical Association Committee on Allied Health Education and Accreditation

Cytotechnologist

CHICAGO—Michael Reese Hospital & Medical Center
University of Chicago Lying-in-Hospital

Electroencephalographic Technologist

SPRINGFIELD—St. John's Hospital

Emergency Medical Tech-Paramedic

JOLIET—Silver Cross Hospital

Histologic Technician

CHICAGO—Holy Cross Hospital
University of Chicago Hospitals and Clinics

PEORIA—St. Francis Hospital and Medical Center
Methodist Medical Center of Illinois

SPRINGFIELD—Memorial Medical Center
St. John's Hospital

Medical Assistants

BELLEVILLE—Belleville Area College

CARTHAGE—Robert Morris College

PALATINE—William Rainey Harper College

RIVER GROVE—Triton College

Medical Laboratory Technician

BELLEVILLE—Belleville Area College

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

GODFREY—Lewis & Clark Community College

GRAYSLAKE—College of Lake County

KANKAKEE—Kankakee Community College

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

Medical Record Administrators

CHICAGO—Chicago State University
University of Illinois at Chicago

NORMAL—Illinois State University

Medical Record Technician

BELLEVILLE—Belleville Area College

CHICAGO—Truman College

DES PLAINES—Oakton Community College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

PALOS HILLS—Moraine Valley Community College

Medical Technologist

BELLEVILLE—St. Elizabeth Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Holy Cross Hospital
Louis A. Weiss Memorial Hospital
Rush-Presbyterian-St. Luke's Medical Center
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
University of Illinois at Chicago Hospital

DANVILLE—Lakeview Medical Center

DECATUR—Decatur Memorial Hospital
St. Mary's Hospital

EVANSTON—Evanston Hospital
National College of Education

FREEPORT—Freeport Memorial Hospital

HINES—Edward Hines Jr. V.A. Hospital

HINSDALE—Hinsdale Hospital

JOLIET—St. Joseph Medical Center

MAYWOOD—Foster G. McGaw Hosp./Loyola University

NORTH CHICAGO—University of Health Sciences/Chicago Medical School

OAK LAWN—Christ Hospital

UNIVERSITY PARK—Governors State University

PARK RIDGE—Lutheran General Hospital

PEORIA—Methodist Medical Center of Illinois
St. Francis Hospital and Medical Center

ROCK ISLAND—Augustana College/ Quad City Hospital

ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital and Medical Center
SwedishAmerican Hospital

SPRINGFIELD—St. John's Hospital
Sangamon State University

Nuclear Medicine Technologist

GLEN ELLYN—College of DuPage

HINES—Edward Hines Jr. VA Hospital

PEORIA—St. Francis Hospital-Medical Center

RIVER GROVE—Triton College

Occupational Therapist

CHICAGO—Chicago State University
University of Illinois at Chicago Hospital
Rush-Presbyterian-St. Luke's Medical Center

Radiation Therapy Technologist

CHICAGO—Chicago State University
Michael Reese Hospital and Medical Center

ELGIN—St. Joseph Hospital

EVANSTON—National College of Education

HINES—Edward Hines Jr. VA Hospital

ROCKFORD—SwedishAmerican Hospital

Radiographer

ARLINGTON HTS.—Northwest Community Hospital

BELLEVILLE—Belleville Area College

CARBONDALE—Southern Illinois University

CENTRALIA—Kaskaskia Junior College

CHAMPAIGN—Parkland College

CHICAGO—Cook County Hospital
Malcolm X College
South Chicago Community Hospital
Wilbur Wright College

DANVILLE—Lake View Medical Center

DECATUR—Decatur Memorial Hospital

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

ELGIN—St. Joseph Hospital

EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

HINSDALE—Hinsdale Hospital

KANKAKEE—Kankakee Community College

MACOMB—McDonough District Hospital

MALTA—Kishwaukee College

MOLINE—Moline Public Hospital

NORMAL—Bloomington-Normal School of Radiology

OLNEY—Richland Memorial Hospital

PALOS HILLS—Moraine Valley Community College

PEORIA—St. Francis Med. Center

QUINCY—Blessing Hospital
St. Mary's Hospital

RIVER GROVE—Triton College

ROCK ISLAND—Franciscan Medical Center

ROCKFORD—Rockford Memorial Hospital
Swedish American Hospital

SOUTH HOLLAND—Thornton Community College

SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

Respiratory Therapist

CARBONDALE—Southern Illinois University

CHAMPAIGN—Parkland College

CHICAGO—Malcolm X College
National College of Education
Northwestern University

EAST CHICAGO—Illinois Central College

MOLINE—Black Hawk College

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

ROCKFORD—Rock Valley College

SPRINGFIELD—Lincoln Land Community College

Respiratory Therapy Technician

BELLEVILLE—Belleville Area College

CHICAGO—Marion Adult Ed. Career Training Ctr., Inc.
South Chicago Community Hospital

EAST PEORIA—Illinois Central College

GLEN ELLYN—College of DuPage

KANKAKEE—Kankakee Community College

MOLINE—Black Hawk College

PALOS HILLS—Moraine Valley Community College

ROCKFORD—Rock Valley College

SPRINGFIELD—St. John's Hospital

WAUKEGAN—Victory Memorial Hospital

Specialist in Blood Bank Technology

CHICAGO—Michael Reese Hospital and Medical Center
Mid-Amer RC Blood Srvs/C.
Hymen Blood Center
University of Illinois at Chicago Hospital

Surgical Technologist

CHAMPAIGN—Parkland College

EAST PEORIA—Illinois Central College

MOLINE—Moline Public Hospital

QUINCY—Blessing Hospital

RIVER GROVE—Triton College

ROCKFORD—SwedishAmerican Hospital

WINFIELD—Central DuPage Hospital

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

Election of senators and representatives is determined in the apportioned districts throughout the state. One senator is elected from each of the 59 districts. Each Senate district contains two House districts. Members of the House of Representatives are elected from these 118 single member House districts.

The General Assembly convenes each year on the second Wednesday of January. The General Assembly is a continuous body during the two year term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. The committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Branch shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They are elected every four years.

STATE OFFICERS 1987

Governor, James R. Thompson, Rep., Chicago
Lieutenant Governor, George H. Ryan, Rep., Kankakee
Secretary of State, Jim Edgar, Rep., Charleston
Comptroller, Roland W. Burris, Dem., Chicago
Treasurer, Jerome Cosentino, Dem., Palos Park
Attorney General, Neil F. Hartigan, Dem., Chicago

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading, when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading, after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (60 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the governor for his consideration.

If the governor thinks the bill should become a law, he will sign it. If the governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each house can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The governor may also return a bill to the legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available at no cost to ISMS members. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

Department of Alcoholism and Substance Abuse

State of Illinois Center, 100 West Randolph Street, Suite 5-600, Chicago, 60601.
222 South College, Springfield 62701.
William T. Atkins, Director

The Illinois Department of Alcoholism and Substance Abuse is the state agency responsible for the public administration and funding of alcoholism and other drug abuse education, treatment, rehabilitation and prevention programs. The Department is responsible for administration of the Illinois triplicate prescription program for designated product controlled substances, scheduling of controlled substances, licensure for drug abuse programs and controlled substances research, training, and administration of initiatives for special populations and a wide variety of demonstration projects. The Department maintains administrative offices in Springfield and Chicago, and regional offices in Springfield, Chicago, Rockford and Mt. Vernon.

Administrative Staff

Daniel W. Behnke, Deputy Director, Bureau of Agency Services
Robert Stachura, Deputy Director, Bureau of Program Services, Division of Support Services
Linda Hargnett, Deputy Director, Bureau of Planning Research and Development
Ronald Nelson, Chief Counsel
Davin Robinson, Special Assistant to the Director
Felix Matlock, Administrator, Div. of Management & Budget
John Woodruff, Administrator, Division of Information Services
Steve Knox, Administrator, Division of Field Services

STATUTORY BODIES

Illinois Interagency Alcoholism and Substance Abuse Board

Lt. Gov. George H. Ryan, *Chairman*
Janet Otwell, Director, Illinois Department on Aging
Ted Sanders, Superintendent, Illinois State Board of Education
Michael P. Lane, Director, Illinois Department of Corrections
Jeremy Margoles, Director, Illinois Department of State Police
Ann Kiley, Director, Illinois Department of Mental Health and Developmental Disabilities
Bernard Turnock, M.D., Director, Illinois Department of Public Health
Susan S. Suter, Director, Illinois Department of Rehabilitation Services
Hon. Jim Edgar, Illinois Secretary of State
Gregory Baise, Secretary, Illinois Department of Transportation
Edward T. Duffy, Director, Illinois Department of Public Aid
Gordon Johnson, Director, Illinois Department of Children and Family Services
Gary L. Clayton, Director, Illinois Department of Registration and Education

Illinois Advisory Council on Alcoholism and Substance Abuse

Honorable L. Michael Getty, *Chairman*
Circuit Court of Cook County
Judy H. Fried, *Vice Chairperson*
Northern Illinois Council on Alcoholism
Russell J. Hagen, Vice Chairman
McLean County Alcohol and Drug Assistance Unit
Jeffrey Davison
Macon County State's Attorney
Donald Paull, Ph.D.
Mental Health Law Division
Robert Holder
Representative of Building Trades
Sam Gaines, M.D.
Hon. John Matijevich
Illinois State Representative
Hon. Thomas Dunn
Illinois State Senate
Hon. Kathleen L. Wojcik
Illinois State Representative
Hon. Frank Watson
Illinois State Senate
Kenneth Robbins
Illinois Hospital Association
Violet Eggert, M.D., Designee
Illinois State Medical Society
Michael Stroden, Designee
Assoc. of Labor-Management Administrators & Consultants on Alcoholism
Antonio Garcia
Hispano Alcoholism Services
David Bingaman
Northwestern House
Rev. Donald M. Hallberg
Lutheran Social Services
Hon. Warren D. Wolfson
Circuit Court of Cook County
Sheriff Richard Doria
DuPage County Court House
Sister Patricia Kilbane
Central States Institute of Addiction
Hon. Terry Steczo
Illinois State Representative
Hon. Dawn Clark Netsch
Illinois State Senator
Hon. Loleta Didrickson
Illinois State Representative
Hon. Forest D. Etheredge
Illinois State Senator
Marian Fiske, Designee
Illinois Nurses Association
Dean Sweet
Sangamon-Menard Alcoholism and Drugs Council
Jack Arkins
Illinois Pharmacists Association
Eldoris Mason
Brass Foundation, Inc.
Larry Wilms
Prairie Center
Peter Bokos, Ph.D.
Interventions, Inc.

Department of Children and Family Services

100 W. Randolph, Sixth Floor, Chicago, 60601
406 East Monroe, Springfield, 62701
Gordon Johnson, Director

The Illinois Department of Children and Family Services is the state agency responsible for providing child welfare and child protection services to children and their families. The current caseload is 39,500 children and families. Services provided by the Department, either directly or through purchase from private agencies, include counseling; the care of children in foster homes, group homes, and institutions; adoption; day care; help to unwed parents, and the licensing and monitoring of some 16,000 child care facilities. The Department also contracts with individuals as advocates and homemakers to work with children and par-

ents on a one-to-one basis.

The Department has three main divisions responsible for delivering services. The Division of Child Protection is responsible for investigating reports of suspected child abuse and neglect. In fiscal year 1986, more than 70,000 children were reported as suspected abuse or neglect victims.

The Division of Youth and Community Services specializes in services for adolescents. It is responsible for a grant-in-aid program of community-based services to troubled youth, juvenile justice and delinquency prevention programs, a multi-agency program for emotionally disturbed youngsters, and a variety of youth employment programs. Through the Department's eight service regions, the Division of Program Operations administers the agency's various service programs for abused, neglected, and dependent children and their families.

Director's Office

Michael Horstman, Executive Deputy Director
Robert T. Blackwell, Special Assistant to the Director
Janis Forte, Special Assistant to the Director
Thomas E. Villiger, Deputy Director, Division of Child Protection
William Hall, Deputy Director, Division of Policy and Plans
Thomas Villiger, Acting Deputy Director, Division of Program Operations
John Petrilli, Acting Deputy Director, Division of Youth and Community Services
David Richards, Deputy Director, Division of Management and Budget
Jo Warfield, Chief, Office of Communication/Community Relations
Mauriece Graham, Chief, Office of Audits
William Curtis, Chief Counsel, Office of Legal Services
Chuck Murphy, Chief, Office of Employee Services
William Rodman, Legislative Liaison
Susan Garland, Acting Chief, Office of Program Review
Linda Avery, Chief, Office of Inter-Agency Coordination

Regional Offices

Thomas Brinton, Region 1A Administrator, Rockford
Thomas Ward, Region 1B Administrator, Peoria
Jack Zentz, Region 2A Administrator, Aurora
Robert Moore, Region 2B Administrator, Chicago
William Gillespie, Region 3A Administrator, Springfield
Willis Hartman, Region 3B Administrator, Champaign
Anthony Jenkins, Region 4 Administrator, East St. Louis
Gene Ruehmkorff, Region 5 Administrator, Marion

Advisory Councils

DCFS Advisory Council, Isaac Singleton, Chairperson
Statewide Citizen's Committee on Child Abuse and Neglect, Catherine Ryan, Chairperson
State Advisory Committee on Day Care, Miriam Klimstra, Acting Chairperson
Illinois Juvenile Justice Commission, Dallas C. Ingemunson, Chairperson
Statewide Foster Care Advisory Committee, Samuel Jenkins, Chairperson

In addition to the above, each of the eight regions has its own advisory committee and various youth planning committees.

Department of Corrections

100 West Randolph, 4th Floor, Chicago 60601
1301 Concordia Ct., Springfield 62794
Michael P. Lane, Director

Leo L. Meyer, Deputy Director-Adult Division
James R. Irving, Deputy Director-Juvenile Division
Anthony Scillia, Deputy Director-Community Services Division
Carl Becker, Deputy Director-Bureau of Administration and Planning
William H. Craine, Ph.D., Deputy Director-Bureau of Employee and Inmate Services
Gerald O. Long, Deputy Director-Bureau of Inspections and Audits
Samuel J. Sublett, Accreditation Manager
Nic Howell, Chief Public Information Officer
Melissa A. Stutler, Chief of Intergovernmental Relations
Dr. Ronald Shansky, Medical Director

Programs: 1) To develop and maintain reception and evaluation units for the purpose of analyzing the security, physical and mental needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, adjustment and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the state.

Department of Mental Health and Developmental Disabilities

401 S. Spring St., Springfield 62706
State of Illinois Center, 100 West Randolph, Suite 6-400, Chicago 60601
Ann M. Kiley, Director

Colette Croze, Deputy Director for Field Services
John Fangman, Deputy Director for Central Operations
Ivan Pavkovic, M.D., Associate Director for Clinical Services
Ugo Formigoni, M.D., Associate Director for Mental Illness
William Murphy, Associate Director for Developmental Disabilities
Terry Brelje, Ph. D., Associate Director for Policy & Special Programs
Virginia Conlee, Director of Training
David Devane, Director of Public Affairs
Pat Evers Alvarez, Legislative Liaison
Vacant, Chief Counsel

STATUTORY BOARDS AND COUNCILS

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Ann M. Kiley, Director, Springfield
Wayne R. Anable, D.O., Chicago
James T. Barter, M.D., Chicago
Robert E. Becker, M.D., Springfield
Robert deVito, M.D., Maywood
Jan Fawcett, M.D., Chicago
Ugo Formigoni, M.D., Springfield
Daniel Offer, M.D., Chicago
George H. Pollock, M.D., Chicago
Lester H. Rudy, M.D., Chicago
Charles Schuster, Ph.D., Chicago
Ivan Pavkovic, M.D., Chicago
Patrick R. Staunton, M.D., Park Ridge
Michael Taylor, M.D., North Chicago

Medical Review Board

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John Crayton, M.D., Chicago
Anthony D'Agostino, M.D., Chicago
Phillip Epstein, M.D., Chicago
Saul Haskell, M.D., Chicago
Zena Lillian, M.D., Chicago
Sergio Rabinovich, M.D., Springfield
Marshall Short, M.D., Chicago
Raymond Teplitz, M.D., Berwyn
Philip Woollcott, M.D., Evanston

Department of Public Aid

100 South Grand Ave. East, Springfield 62762
624 S. Michigan Ave., Chicago 60605
Edward T. Duffy, Director

The Illinois Department of Public Aid assists over one million Illinois residents experiencing financial or medical hardships. The Department administers the following programs: Aid to Families with Dependent Children, Medical Assistance, and Aid to the Aged, Blind, or Disabled. The Department also allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp Program. The Child Support Enforcement Program is a joint effort of the Department, the Attorney General, and local state's attorneys to obtain court-ordered child support from parents. Support enforcement services are provided to any family that needs help collecting child support. Project Chance, a welfare-to-work program, offers job placement services, training, education and support services to guide welfare recipients away from dependency and into the work place. The Department's Office for Hospital Services in the Medical Programs Division administers the Illinois Competitive Access and Reimbursement Equity Program (ICARE), which assures access to quality hospital care for recipients and promotes competition among hospitals for the purchase of their services. Among other initiatives within the Medical Programs Division are nursing home reform and prepaid health programs.

Administrative Staff

Kathleen Breidert, Assistant Director
Michael L. Taylor, Executive Deputy Director
James Stumpf, Office of Legislation
Debra Murrill, Special Assistant to the Director
Randale Valenti, Associate Director, Office of Employment and Social Services
Johnetta W. Jordan, Chief, Office of Public Information
David Peterson, General Counsel, Office of Counseling and Litigation
Mary Ann Langston, Policy & Planning Administrator
James McDonough, Medical Programs Administrator
Norman Ryan, General Services Administrator
Gail Huecker, Operations Administrator
James Gottreich, Chief, Office of Financial Recovery

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Jerry Hickham, Carbondale

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Charles Frazer, M.D., E. St. Louis
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Gayle L. Kates, M.D., Chicago
Terry Mason, M.D., Chicago
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Paul Norris, M.D., Peoria
Ann Pearson, M.D., Springfield
Dennis A. Reter, D.O., Canton
Arthur R. Traugott, M.D., Urbana
Fred Z. White, M.D., Chillicothe

Department of Public Health

535 West Jefferson St., Springfield 62761
Bernard J. Turnock, M.D., Director

The Illinois Department of Public Health promotes the good health of the public through the administration of more than 100 programs and services aimed at preventing illness, eliminating health hazards, regulating health-care facilities, identifying and controlling outbreaks of disease and reducing health-risk factors.

The scope and variety of programs administered by the Department encompass all aspects of preventing disease and disability, thus improving the quality of life for Illinois residents.

The reduction of infant mortality; nutrition services; pre- and postnatal care; dental

health; emergency medical services; childhood immunizations; maintenance of breath-analysis equipment; control of sexually transmitted diseases; assuring the purity of food, milk and drugs; regulation of health-care facilities; elimination of health hazards from the environment; licensure and regulation of swimming pools and other recreational areas; support to local health departments; consumer product safety; and the registration of births, deaths and other vital statistics are among the myriad of programs and services administered by the State Health Department.

Administrative Staff

Chet Atchison, Assistant Director
David King, Deputy Director
Jeff Johnson, Legislative Liaison
Henry Huck, Acting Internal Auditor
Tim O'Brien, Chief Counsel
Dean Schott, Director of Communications

Medical Determinations Board

Recreated, Ch. 127, par. 6.06a
Audley F. Connor, Jr., M.D., Chicago
Richard H. Suhs, M.D., Springfield
Noel M. Bass, M.D., Joliet
Henry P. Russe, M.D., Chicago
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James P. Paulissen, W. Chicago
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Nelson Rose
Division of Electronic Data Processing
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Division of Local Health Administration
George Rudis
Division of Vital Records
Aaron Vangeison
Division of General Services
Pat Tavine

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James Martin
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Division of Laboratories
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Health Services

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Division of Emergency Medical Services and Highway Safety—Leslee Stein
Division of Family Health
Elsie Baukol, M.D.
Division of Implied Consent
William Brey
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James Nelson
Division of Chronic Disease
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Division of LTC Quality Assurance
Bill Bell
Division of Health Facilities Standards
Rebecca Friedman
Division of LTC Field Operations
Patricia Heidenreich
Division of Education and Research
Larry Etzkorn

Health Policy and Planning

Associate Director
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Division of Facilities Development
Raymond Passeri
Division of Health Information and Evaluation
John Noak
Division of Health Policy and Finance
Laura Landrum

STATUTORY BOARDS AND COMMISSIONS

(Allied with Public Health Operations)

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H. Rohmann, Brookfield
Pete Peters, Chicago
Judith Ondercho, Paxton
Mary DeJohnette, Chicago
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Neurological Surgery
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Alan J. Stutz, M.D., Springfield
Therapeutic Radiologist

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Daniel Michalec, D.C., Lake Zurich

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Beverly M. Danhof, Carbondale
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Eugene Rinaldi, Chicago
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Richard Dechert, Decatur
Sister Ann Pitsenberger, OSF, Decatur
Rev. Russell Hagen, Bloomington
Ruth K. Holl, *ex-officio,* IDMHDD
Larry L. Wilms, M.D., Mahomet
Janet A. Norton, R.N., Chicago

Drug Product Selection Program Technical Advisory Council

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James T. O'Donnell, Pharm. D., R.Ph., Chicago
Robert W. Buckman, Ph.D., Chicago
Vincent A. Costanzo, R.Ph., M.D., Chicago
Edward G. Nicholson, R.Ph., D.O., Chicago
Alfonse T. Masi, M.D., Peoria
Dorothy Boggs, R.Ph., Naperville

Hemophilia Advisory Committee, P.A. 80-859

Elizabeth H. Fung, M.S.W., Chicago
Naidene Kirwan, Oak Lawn
John E. Nathan, D.D.S., M.S.D., Chicago
Dean Stanley, Chicago
Margaret Telfer, M.D., Chicago
Robert M. Terzich, Springfield
Andrew E. Weiss, M.D., Peoria
Eldon L. Ham, Chicago

Family Practice Residency Act Advisory Committee Members

Vincent A. Costanzo, M.D., Chicago
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B. Smith Hopkins, M.D., Springfield
Phillip Forman, M.D., River Forest
Silas Purnell, Chicago
Dean Bordeaux, M.D., Peoria
Toni Perrin, East St. Louis
Scott R. Graham, M.D., Flora
John Huther, Ph.D., *ex-officio,* IBHE

Children's Vision Services Advisory Committee

Albert Bucar, O.D., Antioch
Victor F. Feldman, M.D., Champaign
Burton W. Hales, Jr., Chicago
Gloria Calovini, Springfield
Samuel M. Schall, M.D., Chicago
Mrs. Paul Sternberg, Glencoe
Alternates:
Edgar T. Britton, Chicago
Eugene Folk, M.D., Skokie

Children's Hearing Services Advisory Committee

Gloria Calovini, Springfield
Penny Meyers-Dagley, Glen Ellyn
William J. Powell, M.D., Hinsdale
Laura Wilbur, Ph.D., Evanston
Carolyn Young, Chicago
Alternate:
Bonnie Simon, Lombard

Advisory Board of Cancer Control

Tom Baab, Chicago
Nathaniel I. Berlin, M.D., Chicago
Milton F. Darr, Jr., Chicago
Frank R. Hendrickson, M.D. Chicago
Paul Q. Peterson, M.D., M.Ph., Chicago
John E. Ultmann, M.D., Chicago
Irving J. Weigensberg, M.D., Peoria
Allen Hatfield, M.D., Urbana
Charlotte Longwisch, E. Alton

High Blood Pressure Advisory Board

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Henry Betts, M.D., Chicago
Henry L. English, Chicago
Madeline Solomon, Evanston
Geraldine Stroka, Oak Park
Charles Thompson, M.D., Chicago
Ruth Toomey, Wood River
Paul LaFata, M.D., Springfield
Richard Christiansen, M.D., Rockford

Experimental Organ Transplantation Procedures Advisory Board

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Donald West King, M.D., Chicago
Randy A. Keinstra, M.D., Springfield
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Lawrence M. Gartner, M.D., Chicago
Richard J. Sassetti, M.D., Chicago
Jerry Staub, M.D., Rockford
James S. Wolf, M.D., Chicago
Robert Bruce Karp, M.D., Chicago
Eddie Moore, M.D., Glencoe
Motilal Raichand, M.D., Oak Brook

Health and Hazardous Substances Coordinating Council

Gary Miller, Springfield
John Cooper, Ph.D., Springfield
Roger Kanerva, Springfield
Bernard J. Turnock, M.D., M.P.H., Springfield
Robert Schwarberg, Springfield
Thomas Wallin, Springfield
Jacob A. Brody, M.D., Chicago

State Emergency Medical Services Council

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Ron W. Lee, M.D., Chicago
John M. Holland, M.D., Springfield
Joseph Winterhalter, M.D., Jacksonville
Donald Walsh, Chicago
Lanson W. Russell, Peotone
John W. Daley, M.D., South Holland
Fred Kimmel, Chicago
Neil Wigder, M.D., Oak Lawn
Robert L. Harris, Olympia Fields
Virginia Mulligan, Chicago
Keith Smith, Lansing
Arnold Downs, Cary
Faye Kirk, Springfield

Alzheimer's Disease Advisory Committee

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Sanford I. Finkel, M.D., Wilmette
Jacob H. Fox, M.D., Chicago
Mary Graber Hagarty, R.N., Oak Park
Ruth Rabyne, Chicago
Jane G. Kelley, Rockford
Patricia L. Prillaman, Bloomington
Mary Barringer, R.N., Springfield
Richard L. Benkin, Ph.D., Lincolnwood
George L. Everingham, Jr., Carbondale
Nelly Ryan, A.C.S.W., Springfield
Larry S. Goldman, M.D., Chicago
Edmund G. Lawler, Midlothian
Nancy M. Sandercock, Abingdon
Donna Mae Litwiler, Ingleside
Homer M. Kuder, St. Joseph
Florence A. Clark, R.N., Pekin

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Bee White, Springfield
Gail Gudmundsen, Hoffman Estates
Thomas Regnier, Peoria
Pamela Ranson, Forest Park

Nursing Baccalaureate Assistance Advisory Council

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Lois Frels, Ph.D, Hillsdale
Rev. Everett Hageman, Shipman
Lea G. Acord, Ph.D., Glen Ellyn
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Illinois Department of Public Health
525 W. Jefferson
Springfield, 62761
Phone: (217) 785-2080

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Illinois Department of Public Health
Division of Disease Control

For information contact:
Mary Mahoney—Coordinator, Direct Services Programs
Illinois Department of Public Health
Room 150, 535 West Jefferson Street, Springfield, 62761
Phone (217) 782-3303

Department of Registration and Education

320 W. Washington Street, Springfield 62786
100 W. Randolph St., Suite 9-300, Chicago 60601
Gary L. Clayton, Director

Glen D. Crick,
Deputy Director/Statewide Enforcement
Russ Friedewald,
Deputy Director/Licensing and Testing
Tom Battista, Chief of Prosecutions
Tom Killala, Chief of Medical Investigations

The Department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, and occupations, including the Medical Practice Act.

The Medical Practice Examining Committee, appointed by the director of the Department, operates within the framework of the Act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, reviews alleged violations of the Medical Practice Act, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

Illinois Medical Practice Examining Committee

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David S. Fox, M.D., Chicago
Lawrence L. Hirsch, M.D., Northbrook
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Warren H. Staley, M.D., Chicago
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Irene Caruso, M.D., Galesburg
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Risher Watts, Jr., M.D., River Forest
Charles K. Wells, M.D., Mount Vernon
Karl H. Zimmer, D.C., Evanston
Vicki Bahr, Peoria
Virgil C. Wikoff, Champaign

MEDICAL PRACTICE ACT

The Illinois Medical Practice Act underwent sunset review in 1987, and the new Act is a document of importance to every Illinois physician. Although its length prohibits publication of the complete text, members are encouraged to obtain a copy of the Act from the Department of Registration and Education, 320 W. Washington Street, Springfield 62786. Readers are also referred to the September, 1987, *IMJ* for highlights of the new Act and a review of attendant issues.

Department of Rehabilitation Services

623 East Adams Street, Springfield, 62706
Susan S. Suter, Director

The Department of Rehabilitation Services (DORS) is the state's leading agency helping children and adults with disabilities to reach their full potential and their goals for a productive independent life. Funded by state and federal funds, DORS provides a variety of rehabilitation services to eligible persons, including children who cannot be adequately served by their local public schools; adults of or near working age who have diagnosable physical and/or mental disabilities which interfere with their ability to get or keep jobs; and adults with severe disabilities under age 60 who are at risk of institutionalization but who could remain at home if certain, specific services were provided.

DORS assists clients in selecting the needed services; serves as a link to service groups, rehabilitation facilities and other governmental agencies; and makes medical eligibility determinations for persons applying for benefits under the Social Security Disability Insurance and Supplemental Security Income programs.

DORS offers its services through a number of program components, including the Vocational Rehabilitation Program, the Home Services Program, the Illinois Visually Handicapped Institute, Community/Field Services for the Visually Handicapped, the Illinois School for the Deaf, the Illinois Children's School and Rehabilitation Center, the Illinois School for the Visually Impaired, secondary school work experiences and the Vending Stand Program.

Illinois Health Care Cost Containment Council

516 E. Monroe St., Suite 200, Springfield 62701
Marilyn Plomann, Executive Director

In August, 1984, Illinois Governor James R. Thompson signed into law Senate Bill 495, which created a new body reporting directly to the Illinois General Assembly independent of any specific code department. That body, the Illinois Health Care Cost Containment Council, was appointed to fulfill the legislative mandate to hold down the cost of health care in Illinois. It was instructed to establish a data system which will collect bills for all hospital discharges, to prepare quarterly public reports on health care charge and utilization trends and to recommend additional methods to restrain the rise in health care costs. Three health care providers, three consumers, two insurers and three representatives of the business community were appointed.

Health Care Provider Representatives:
Charles B. Van Vorst, Champaign
Robert K. Burger, Chicago (ISMS)
Ruth Rothstein, Chicago

Business Community Representatives:
Johanna M. Lund, Rockford, *Chairman*
Raymond B. Werntz, Chicago
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Consumer Representatives:
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Larry Lawler, Decatur
Edward H. Mazur, Ph.D., Chicago

Insurance Industry Representatives:
Don Ames, Chicago
Charles R. Goulet, Geneva

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the reference section. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

Name: _____ **City:** _____ **Zip:** _____

Address: _____

Telephone:( ) _____

County Medical Society: _____

Medical specialty and type of practice: _____

Committee in which interested: _____

Expertise for this committee: _____

Send to: Chairman, Board of Trustees, Illinois State Medical Society
Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Public Health

AIDS Statistics

The following statistics represent the number and types of AIDS cases in Illinois as of August 31, 1987.

Total number of AIDS cases since 1982:	1136
Total percent dead	55%
Males	1095
Females	41
Chicago residents	829
Chicago metropolitan	1017
Downstate Illinois	118

Counties with five or more cases: Cook (948), DuPage (22), Lake (22), Kane (18), St. Clair (13), Champaign (12), Sangamon (12), Randolph (11), Winnebago (8), Peoria (6), and McLean (5).

Transmission Categories	
Homosexual and bisexual male	77%
Homosexual male and IV drug user	5%
IV drug user	6%
Hemophiliac	1%
Heterosexual*	3%
Transfusions	4%
Parent with AIDS/At risk	1%
None of the above	3%

Age:	
Under 13	1%
13-19	1%
20-29	22%
30-39	43%
40-49	22%
Over 50	11%

Race/Ethnic:	
White	64%
Black	28%
Hispanic	7%
Other	1%

**This included 24 persons who have had heterosexual contact with a person with AIDS or at risk for AIDS and 12 persons born in countries where heterosexual transmission is believed to be the major mode of transmission*

(Source: IDPH Monthly AIDS Surveillance Report, 8/31/87)

New Procedures For Screening Newborns

Effective July 1, 1987 the Division of Laboratories of the Illinois Department of Public Health initiated procedures to screen all newborns for congenital adrenal hyperplasia (CAH). Illinois also screens for biotinidase deficiency, galactosemia, congenital primary hypothyroidism and phenylketonuria (PKU).

If the diagnosis of CAH due to 21-hydroxylase deficiency is not made at birth, males can succumb in early infancy from a disturbance in salt metabolism and females may undergo virilization.

The Department is screening for 17-OH-progesterone levels to detect the simple virilizing form of congenital adrenal hyperplasia. An elevated level of 17-OH progesterone is an indicator of 21-hydroxylase deficiency. In instances where the 17-OH progesterone level is highly elevated, the infant's attending physician will be notified by the Illinois Department of Public Health (Genetic Diseases Program) and referral assistance offered. When the test result is only slightly elevated, a request for a second test on filter paper will be made. If this test is also suspect, the physician handling the case will be asked to refer the parents to the designated pediatric endocrinologist in their area for a definitive diagnosis and treatment.

The addition of CAH to the screening roster will affect all hospitals and attending physicians delivering babies in Illinois. Specimen collection procedures will remain the same as those currently used. Please note that babies born outside the state to Illinois residents may not have had this screening.

If further information or assistance is required, please contact Sydney Kling, R.N., Administrator, Genetic Diseases Program, at 217/785-4522.
(Source: September 3, 1987 letter from IDPH Director B. Turnock)

From the Department of Registration and Education (DRE)

Addresses for Licenses

To minimize delays in receiving license renewal notices and to assist DRE in expediting license processing the Department recommends that physicians use their residence addresses on their physician-surgeon licenses. The law requires that all controlled substance licenses must be issued to a business address. When making address changes, the physician should indicate to the Department which license(s) should be cor-

rected, *i.e.,* 003036-0000-1 Controlled Substance License, or 036-0000 Physician-Surgeon License.

ISMS suggests that physicians who live in an adjacent state but practice in Illinois use their Illinois address. *(Source: July 24, 1987 correspondence from DRE Director Gary L. Clayton)*

Medical Disciplinary Orders

- *Zarina Bandukwala* (Lic. # 036-062340 & 003-036-062340)
  Effective June 4, 1987, Dr. Bandukwala's medical and controlled substance licenses were restored and placed on probation.
- *Joseph L. Giacchino* (Lic. # 036-050366 & 003-036-050366-1)
  Effective June 4, 1987, Dr. Giacchino's medical and controlled substance licenses were summarily suspended pending a hearing on the facts.
- *Francis H. Ketterer* (Lic. # 036-020042 & 003-036-020042-1)
  Effective June 19, 1987, Dr. Ketterer's controlled substance license was restricted to suspend his ability to prescribe, dispense and distribute anorectic agents.
- *Theodore Little* (Lic. # 036-040466 & 003-036-040466-1)
  Effective July 6, 1987, Dr. Little's medical and controlled substance licenses were placed on probation and suspended in part.
- *Clifford Lynch* (Lic. # 003-036-038520-1)
  Effective June 26, 1987, Dr. Lynch's controlled substance license was placed on a three year probation.
- *Burdis Mazeika* (Lic. # 036-054931 & 003-036-054931-1)
  Effective July 6, 1987 Dr. Mazeika's medical license was placed on probation and his controlled substance license suspended.
- *Benigno J. Rodriguez* (Lic. # 036-031885 & 003-036-031885-1)
  Effective June 19, 1987, Dr. Rodriguez's medical and controlled substance licenses were placed on probation subject to certain conditions.
- *Visualdis Ziedins* (Lic. # 003-036-032657-1)
  Effective June 26, 1987, Dr. Ziedins' controlled substance license was placed on probation for two years.

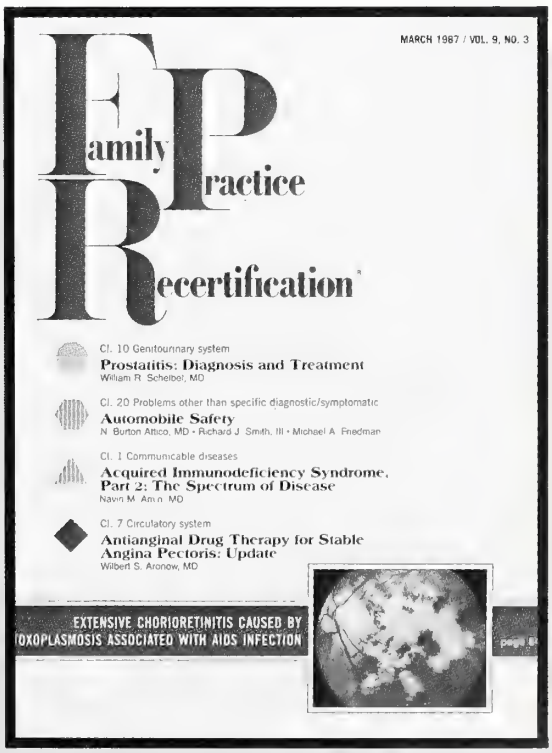
(Source: Orders received from DRE) ◀

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DOCTOR'S NEWS

PRIOR ACTS COVERAGE CLARIFIED

The Illinois State Medical Inter-Insurance Exchange has received a number of inquiries regarding "prior acts" coverage (coverage for incidents that may have occurred while a previous claims-made policy was in effect but are as yet unreported and therefore not covered).

The Exchange currently does not offer prior acts coverage. Nor are there any plans to do so in the future. The Exchange Board of Governors believes that the unpredictable nature of potential losses would make it difficult to set appropriate premium levels for such coverage. The Board also believes that avoidance of additional risks posed by insuring physicians previously with other carriers is among the Exchange's duties to its current policyholders.

Prior acts coverage probably would be at least as expensive as tail coverage from the previous insurer and would present additional difficulties in cases where physicians obtaining Exchange policies were previously insured in other states. The Exchange now insures only physicians practicing in Illinois.

WARNING ABOUT INSURERS

The Illinois Department of Insurance is cautioning Illinois physicians about obtaining medical malpractice insurance from two Guam-based insurance companies. Neither Casualty Assurance Risk Insurance Brokerage Company, nor its affiliate, New World Financial Trading and Reinsurance Corp., are authorized to operate in Illinois.

The Department reports that some of the two companies' equity subscribers were involved with Professional Risk Insurers Management Exclusive Co., Ltd. (PRIME), which was barred from selling medical malpractice insurance in Illinois in 1986.

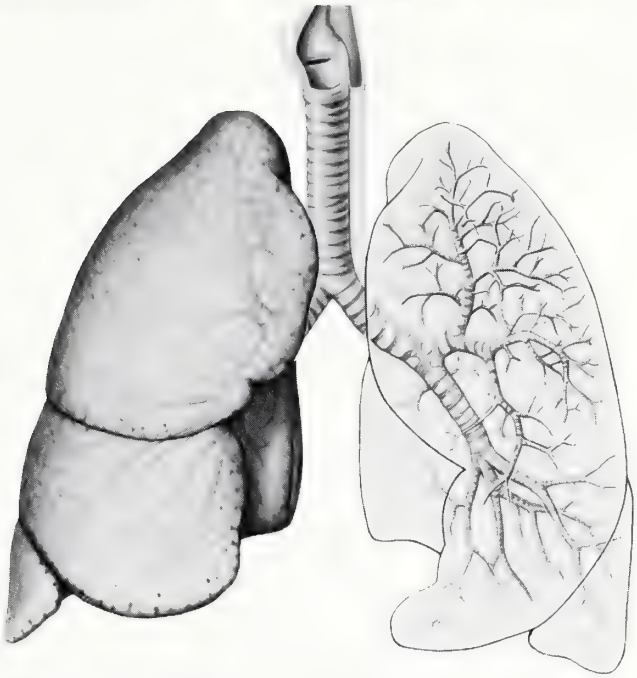
PHYSICIANS IN THE NEWS

Paul A. Knepper, M.D., Ph.D., has been named the 1987 Olga Keith Wiess Scholar presented by Research to Prevent Blindness, Inc. Dr. Knepper, an ophthalmologist and cell biologist, is affiliated with Children's Memorial Hospital, Chicago . . . Mercy Hospital and Medical Center recently announced its newly elected officers. Elected to two year terms were: **Jere E. Freidheim, M.D.,** Flossmoor, president; **Manuel P.A. Claudio, M.D.,** Hoffman Estates, president-elect and **James P. Fairbairn, Jr., M.D.,** LaGrange, secretary-treasurer.

AMA Practice Management Workshops

AMA is offering several practice management workshops over the next several months. Among the topics to be covered are: starting a successful practice; joining a group practice; alternative delivery systems; obtaining fair reimbursement and retirement. Cost of the two day workshop is $245 for members and $295 for nonmembers. For registration information contact the AMA Practice Management Registrar at (312) 645-4958 (collect), or write to the American Medical Association, Department of Practice Management, 535 N. Dearborn St., Chicago, IL 60610; Attn: Registrar. ◀

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Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci)

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

CARBONDALE:
Multi-specialty group needs the following physicians: Allergist, OB/GYN, Neurologist, Family Practitioner, Orthopedic Surgeon. Contact: Bill Harris, 2601 West Main, Carbondale 62901; (618) 549-5361. (12)

CENTRAL ILLINOIS:
Internal Medicine; Solo Practice. Office is located within 40 miles of two medical schools and one block from Millikin University. There are 2 open staff 400-bed hospitals. The population of the city is 100,000, trade area is 250,000 and 140 physicians. The method of payment is fee-for-service. Contact: Charles F. Downing, M.D., 1067 West Main Street, Decatur 62522; (217) 423-9775. (12)

CHICAGO SUBURBAN:
MacNeal Hospital, major teaching affiliate of Rush-Presbyterian-St. Luke's Medical Center, seeks Family Practitioners. Opportunities include: Private Practice, Solo, Partnership, Practices for sale. Salaried positions: Family Center/Occupational Medicine. Individualized comprehensive financial package. BE/BC Family Practice. Forward C.V., contact: Physician Affairs, 3249 S. Oak Park, Berwyn 60402. (12)

CLIFTON:
Board certified OB/GYN. 70 miles south of Chicago. Rural community hospital. Service area population 10,000. Excellent financial benefits, including guaranteed income, modern office space adjacent to hospital, staffing and moving expenses. Contact: Dianne Soucie, Administrator, Central Hospital, P.O. Box 68, Clifton 60927; (815) 694-2392. (10)

FLORA:
Population of county 15,000+. Opportunity for General Surgeon supported by three FP, OB/GYN, Internist, and Hand Surgeon. Progressive family-oriented community, excellent school system. Close to St. Louis, Springfield, & Evansville. Contact John Monnaham, Administrator, Clay County Hospital, 700 North Mill, Flora 62839. (10)

LIBERTYVILLE:
Group of 4 Primary Care Physicians: 1-General Practitioner, 1-Internal Medicine, 2-F.P.—in Lake County we need additional F.P. with O.B. interest. Offices in Libertyville, Gurnee and Antioch. 30 miles north of Chicago. Guaranteed 1st year salary. All recreational facilities nearby. Contact: Dr. David D. Soo, Rt. 1, Box 351, Libertyville 60048; (312) 362-9050. (12)

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

November

General Medicine

Teaching Stress Management and Relaxation Skills
For: Physicians, nurses, health professionals. Workshop, November 9-13, La Crosse, WI. **Sponsor:** University of Wisconsin-La Crosse, Wisconsin Heart Institute, La Crosse, WI. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours. **Contact:** Philip K. Wilson. **Phone:** (608) 785-8686.

Newer Antithrombotic Drugs—Newer Strategies in the Management of Thrombotic Disorders
For: Neurosurgeons, cardiologists, surgeons, hematologists, oncologists. Symposium, November 12-14, Oakbrook Hyatt, Oakbrook. **Sponsor:** Loyola University of Chicago, Stritch School of Medicine, 2160 South First Avenue, Maywood, IL 60153. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 23 hours. **Contact:** Jaweed Fareed, Ph.D. **Phone:** (312) 531-3236.

Wayne State University 35th Annual Detroit Trauma Symposium
For: Emergency physicians, surgeons. Symposium, November 6 & 7, Detroit. **Sponsor:** Wayne State University, Michigan Comm. on Trauma, American College of Surgeons, Harper Hospital, 3990 John Rd. Detroit, MI 48201. **Fee:** $130 Physicians/$80 Residents & Allied Health Professionals. **Reg. Limit:** 260. **Credit:** Category 1: 9 hours. **Contact:** Marjorie Norum. **Phone:** (313) 745-2345.

Internal Medicine

Advances in Internal Medicine, 1987
For: Internists, Lecture, November 2-6, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Fee:** $525 **Reg. Limit:** 90 **Credit:** Category: 1: 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Neurology

Clinical Neuroimmunology V
For: Neurologists. Symposium, November 5-8, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Oncology

Antiestrogens in Early Breast Cancer: Current Therapy and Future Prospects
For: Oncologists, family physicians. Lecture, November 24, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K.P. Reddy, MD. **Phone:** (815) 756-1521 × 3486.

Pathology

Seminar on AIDS, Part II—(Laboratory Diagnosis & Personnel Precautions)
For: Pathologists, Lecture, November 9, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society and Michael Reese Hospital. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Primary Care

Diagnosis & Pitfalls of Common Hand Injuries
For: Physicians who treat acute hand trauma. Course, November 21, Chicago. **Sponsor:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, CO 80014. **Fee:** $125 for physicians; $75 for residents. **Reg. Limit:** 250. **Credit:** Category 1: 7 hours. **Contact:** Anne Turner. **Phone:** (303) 755-4588.

Psychiatry

Multiple Personality/Dissociative States
For: Psychiatrists, psychologists, nurses, social workers. Lecture/Workshop, November 5-7. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 25 hours. **Contact:** Office of Continuing Education. **Phone:** (312) 942-7095.

Pulmonary Disease

Weekend Refresher in Pulmonary Diseases
For: Primary care physicians. Lecture, Case Studies, Q&A, November 13-14, Eagle Ridge Inn & Resort, Galena, IL. **Sponsor:** University of Illinois College of Medicine at Chicago, 912 South Wood St., 2 North, Chicago, IL 60612. **Fee:** $180. **Reg. Limit:** 120. **Credit:** Category 1: 10 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-8025.

Sports Medicine

For: Interested physicians. Lecture, November 11-13, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Fee:** $370. **Reg. Limit:** 90. **Credit:** Category: 1: 25 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Surgery

Recent Advances in Rehabilitation of the Hand
For: Physicians. Lecture, November 3. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K.P. Reddy, M.D. Phone: (815) 756-1521 × 3486.

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons and internists. Lecture, November 7, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Fee:** $160. **Reg. Limit:** 75. **Credit:** Category: 1: 7 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Spinal Cord Injuries
For: Surgeons. Lecture, November 17, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt 23 and Bethany Road, DeKalb. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour, AAFP Prescribed 1 hour. **Contact:** K.P. Reddy, M.D. **Phone:** (815) 756-1521 × 3486.

December

Cardiology

New Management Choices in Cardiology: Controversies and Otherwise
For: Physicians and other health professionals. Conference, December 4, Madison, WI. **Sponsor:** University of Wisconsin-Madison, 465A WARF Building, 610 Walnut Street, Madison, WI 53705. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category: 1: 7 hours, AOA Category 2-D and University of Wisconsin CEU's. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Advances in Aortic and Mitral Stenosis.
For: Cardiologists. Course, December 11-12, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: To be determined. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

General Medicine

Symposium on the Prevention and Treatment of Pressure Ulcers.
For: Family practitioners, dermatologists, geriatrics. Symposium, December 12-13, Oakbrook, IL. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: To be determined. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Neurology

Neurology for the Non-Neurologist.
For: Family practitioners, internists, psychiatrists. Lecture/workshop, December 9-11. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago. **Fee:** $400. **Reg. Limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Office of Continuing Education. **Phone:** (312) 942-7095.

Obstetrics and Gynecology

Problem Solving in Gynecologic Endocrinology & Infertility
For: Obstetricians, gynecologists. Course, December 11-12, The Knickerbocker Hotel, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

EKG

(continued from page 220)

Answers: 1. A, B, C. 2. A, B, C.

The twelve lead ECG shows sinus rhythm at a rate of 80 beats per minute and normal PR, QRS, and Q-T intervals. There are QS waves in leads V_3 and V_4 with significant Q waves in leads V_5, V_6, II, III, and AVF. There is marked ST segment elevation in leads V_2 to V_6 with a lesser degree of ST elevation in leads II, III, and AVF.

These are the findings of an anterior wall and an inferior wall myocardial infarction. Without the history and old ECG tracings, you could call both of these acute infarctions—or an acute anterior apical myocardial infarction, but we know the inferior infarction occurred two years ago. The anterior wall infarction is acute, even the premature ventricular beat seen in the $V_1V_2V_3$ column has a Q wave and ST segment elevation.

All of the answers in question 2 are correct except intravenous or intracoronary thrombolysis with streptokinase or urokinase. Most of the studies utilizing thrombolysis in the acute myocardial infarction patient suggest efficacy if the streptokinase is started within four hours of the onset of chest pain.[1] This patient arrived too late for thrombolysis, some ten hours after the onset of chest heaviness.

He was admitted to the coronary care unit where he developed dyspnea. Acute pulmonary edema was diagnosed and treated with oxygen, small doses of morphine sulfate, and intravenous furosemide. A pulmonary artery catheter was placed and the pulmonary artery pressure was 48/25mmHg with a pulmonary capillary wedge of 22mHg. The patient responded and had an uneventful course in the hospital.

Prior to hospital discharge, a low level exercise ECG was performed. The patient could only walk two minutes on the Naughton protocol exercise ECG with ST segment elevation in the area of the anterior infarction. He stopped exercise because of dyspnea, but experienced no chest discomfort. He refused any further work-up including coronary angiography, but agreed to go to a cardiac rehabilitation program.

References

1. Gissi: "Effectiveness of Intravenous Thrombolytic Treatment in Acute Myocardial Infarction," *The Lancet,* 22:397-401, 1986.

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December, 1987-February, 1988

Urologic Pathology and Radiology
December 7-11, 1987
Specialty Review in Thoracic Surgery
January 18-23, 1988
Review Course in Neurological Surgery
February 5-14, 1988
Biologic Basis of Neurology and Psychiatry
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February 29-March 4, 1988
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The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

November 2	Lutheran General Hospital	*Park Ridge*
November 2	Prairie State College	*Chicago Heights*
November 2	St. Francis Hospital	*Evanston*
November 2	West Suburban Hospital & Med. Ctr.	*Oak Park*
November 3	Rush North Shore Med. Ctr.	*Skokie*
November 3	Skokie Valley Hospital	*Skokie*
November 9	Condell Memorial Hospital	*Libertyville*
November 15	Victory Memorial Hospital	*Waukegan*
November 16	Little Company of Mary Hospital	*Evergreen Park*
To Be Announced	Ambutal	*Crystal Lake*
To Be Announced	Christ Hospital	*Oak Lawn*
To Be Announced	Copley Memorial Hospital	*Aurora*
To Be Announced	Delnor Community Hospital	*St. Charles*
To Be Announced	Dreyer Clinic	*Aurora*
To Be Announced	Highland Park Hospital	*Highland Park*
To Be Announced	Hinsdale Sanitarium and Hospital	*Hinsdale*
To Be Announced	Ingalls Memorial Hospital	*Harvey*
To Be Announced	Memorial Hosp. for McHenry Cty.	*Woodstock*
To Be Announced	Mendota Community Hospital	*Mendota*
To Be Announced	Northern Illinois Medical Center	*McHenry*
To Be Announced	Olympia Fields Osteo. Med. Ctr.	*Olympia Fields*
To Be Announced	Sherman Hospital	*Elgin*
To Be Announced	St. Francis Hospital	*Blue Island*

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Exchange Insights

October 1987

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

Avoiding Liability in the Referral and Consultation Process



In order to provide the best patient care possible, it is often necessary to refer (or transfer) the patient to a specialist, or to consult another physician about a particular case. Failure to make a timely referral or consult a specialist is a common allegation in medical professional liability suits. In some instances, when a physician does consult a specialist or make a referral, the quality of care rendered suffers due to a lack of communication between the attending physician and the specialist. This can result in litigation. Physicians should know which situations require consultation or referral, and how to prevent potential misunderstandings inherent in the referral and consultation process.

Physicians are required by law to consult with or refer the patient to another physician whenever the physician knows or should know that he cannot manage his patient's condition with likely success. To determine whether a patient should be referred or a consult requested, the physician must honestly evaluate his own skills and the various treatments available in light of the patient's condition. In short, he must acknowledge the limitations of his knowledge and ability.

In general, some of the clinical indications for consultation or referral include the following:

☐ Unfamiliarity with the patient's illness or injury preventing a confident diagnosis.

When a physician is unable to arrive at a diagnosis, he should obtain a consultation. If he fails to seek a timely consultation in such a situation, and it can be demonstrated that a specialist consultation would have prevented misdiagnosis or delay in diagnosis, the physician may be held liable for negligence.

☐ No improvement in the patient's condition within a reasonable period of time.

A consultant should be brought in, or the patient referred, when the attending physician is unable to achieve desired results from his prescribed course of treatment within a reasonable period of time. If the patient's condition deteriorates, and it can be shown that the patient would have improved if referred to a specialist, then the physician may be exposing himself to a claim of negligence.

☐ Knowledge that other treatment would likely be beneficial to the patient.

If a physician knows or should know that treatment by a specialist is reasonably available and would benefit the patient, he may be negligent if he does not advise the patient of that fact.

☐ Unavailability of facilities or equipment that would be of significant benefit to the patient.

A physician who knows what is wrong with the patient and exactly what treatment is necessary may have an obligation to refer the patient to a hospital which has the facilities or equipment that would be of significant benefit to the patient.

In deciding whether to consult another physician or refer a patient, it is also important to consider the patient's wishes. Patients are often obliged to request a second opinion or transfer to another physician. The physician should always try to honor a patient's request, but should base his recommendation on the medical necessity or clinical indications of the case.

Once a decision has been made to seek a consult or refer the patient to a specialist, it is important that both physicians communicate effectively about the case. A lack of communication between attending physician and

specialist is a common cause of malpractice suits. Problems all too often result when each physician assumes that the other was handling the management and direct care of the patient, while in fact neither physician was caring for the patient.

When the attending physician consults a specialist for a particular problem, it is generally assumed that the attending physician will continue to supervise the patient's care. However, the consultant has a duty to inform the attending physician of the results of his consultation as soon as they are available. A radiologist who correctly diagnoses a problem may be found liable if he fails to adequately communicate his diagnosis so that the appropriate treatment can be rendered. It is still the attending physician's ultimate responsibility to retrieve the results of any test or consultation he has requested, as it is his duty to treat based on those results. It is important that the attending physician implement an efficient follow-up system.

When referring or transferring a patient to another physician, it is not as readily assumed that the attending physician will supervise the patient's case. The attending physician and the specialist to whom the patient is referred must clarify who will be supervising the case, or whether the patient will be jointly supervised. This is necessary to ensure that the patient does not get "lost in the shuffle."

It is crucial that the attending physician provide the specialist with enough information about the patient's case to allow an adequate appraisal. The specialist should be given a summary or copy of the medical records and patient history, along with any x-rays or lab reports. In addition, the physician should specifically indicate the reason for the referral or consult. For example, if a radiologist receives a request for an evaluation of an x-ray without basic clinical information about the patient or an indication of the purpose for the consult, he or she will have great difficulty making an informed, educated evaluation. This can subject the patient to needless risk.

It is equally important that the purpose and need of the referral or consult be explained fully to the patient so that he or she understands its importance. Specific procedural instructions should also be provided, such as how soon the patient should make an appointment with the consultant, and which doctor will be supervising the case. In addition, the patient should be informed about the probable procedures and/or tests that the specialist is likely to prescribe. The patient should be given ample time to digest the information and ask questions.

The attending physician is usually not liable for any negligence committed by the physician to whom he referred a patient, provided that he has selected him carefully. If the attending physician knows or should have known of the referred physician's lack of ability to properly care for the patient's condition or injury, then he, as well as the referred physician, may be liable for the alleged negligence performed. The attending physician may also be liable for the specialist's negligence if they are associates, or if he is treating the patient in conjunction with the specialist.

In summary, it is important to not only recognize when a referral or consultation is necessary, but to also implement the process effectively. Don't let your pride stop or delay you in requesting a consultation or referring your patient to a qualified specialist. The opinion of another physician in your specialty or another specialty will often yield valuable information or suggestions for treatment, and will help protect you from possible legal action.

Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

Protect Our Children



They talk loud and listen to loud music and they dance a lot. They wear weird clothes and do funny things to their hair. They don't like to read and you can't depend on them.

Yes I'm talking about a minority group—our teenagers. My wife, Anne, and I have had six of them (most of which have now entered the mainstream as "young adults") and survived.

Our Society, through its elected delegates, and in response to a number of resolutions passed at the annual meeting, has set out this year to alert and educate the people of Illinois about teen health problems. As president, I have been meeting the media and speaking on these issues throughout the state during my tour. TV, radio and the print media have welcomed the message with open arms. (They were sick of hearing about malpractice problems, although I get it all in anyway.)

I want to give you an idea of what the Society is saying and some background to help you through your own media and public contacts, so that you can alert and teach your communities about these problems.

Serious teen health problems are usually related to complications of sex and pregnancy. Alcoholism and drug abuse are serious as well, and may lead to sexual experimentation. The one new factor in the above is the spectre of AIDS.

In the past, a teen whose wrong choice or foolish acts had resulted in gonorrhea or "clap" would see his family doctor about an embarrassing, painful and sobering matter, be treated and be cured. Those teens might have "learned their lesson," decided to "fly straight" and control themselves and eventually, marry and have children.

Now, a casual sexual encounter may result in HIV infection, and for this, there is no cure. The implications are devastating.

The teen pregnancy rate (12.5% of all births in the state, and 50% of all unmarried mothers) and sexual promiscuity among teenagers show that the AIDS virus danger is to be feared in the teen cohort.

No cure exists. HIV virus in the body precludes marriage and children, and may mean early death. No children. No grandchildren. No future. We thought polio was bad when it endangered our children, but surely the AIDS danger is much worse. We know how to prevent AIDS. Abstinence from sex with an infected person is the main answer.

No one can predict what the future development of this disease will be. Many questions are not answerable now, but as physicians, we will be in the thick of it. We will write the order for every engaged couple to undergo an AIDS premarital test, and we will give both results to each partner and counsel them if they are positive. While positive results will be very sparse, let us use this test as a means of educating our patients and their future families about this disease. Sex education, early and complete, and taught at home and school, will have to be accurate and reach everyone. We, as physicians, may have to lead in encouraging parents, school boards, priests and ministers to make sex education a paramount concern.

Condoms are not the answer. Ten percent of couples who use them to prevent pregnancy become parents. Defective goods add another four-to-five percent of failures.

We have lived through the polio problem of the 40s and 50s and now we have a new and more dangerous enemy. Let us take care of its victims as best we can. I'm sure the medical profession, the nurses, doctors and all, will do their jobs.

We have signs in all our towns saying "Slow—Protect Our Children." Let's do so, but we have to hurry. ◀

Edward J. Fesco, M.D.

Edward J. Fesco, M.D.
President

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Please see following page for brief summary of prescribing information.

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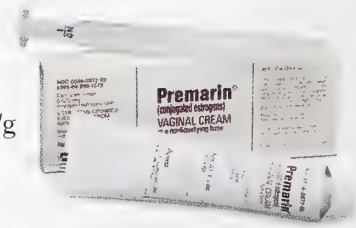
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For atrophic vaginitis

PREMARIN®
(conjugated estrogens)

Vaginal Cream

0.625 mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important, product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3, increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion, cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance, aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Osteoporosis. Female castration. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart DM, Clark DM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. **2.** Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.

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THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Virginia McDonald, M.D., department of radiology, Loyola University Medical Center, Maywood.

Patient 1: This 56-year-old previously healthy man has had a cough for two months.

Patient 2: This 68-year-old woman had a laryngectomy and radiotherapy for a laryngeal carcinoma three years ago. She has had night sweats, anorexia, weight loss and blood-streaked sputum for the past three weeks.

Patient 3: This 49-year-old man has had dyspnea on exertion and daily fevers to 102° for one week prior to hospitalization.

All of the patients have the same disease. A diagnostic procedure was completed in each case.

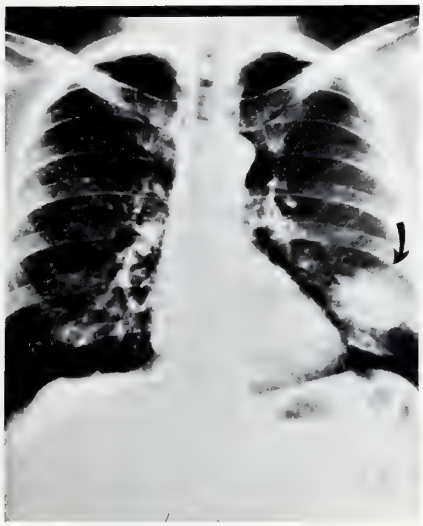


Figure 1
Patient 1
There is an ill-defined left lower lobe mass. (arrow)

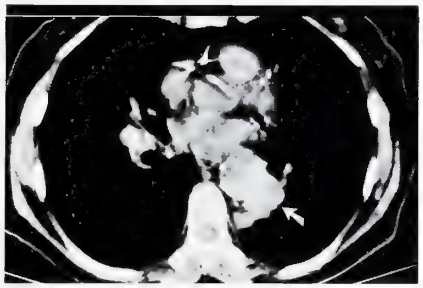


Figure 2
Patient 2
CT shows an irregular mass (arrow) contiguous with the descending aorta.



Figure 3
Patient 3
There is extensive consolidation of left lung and perihilar consolidation of right lung.

Your diagnosis?

1. Gilchrist's disease
2. Chicago disease
3. Blastomycosis
4. Namekagon fever
5. All of the above

(continued on page 389)

ABSTRACTS OF ACTIONS

September 19, 1987 *ISMS Conference Complex*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

Public Media Campaign

Phase I of a public media campaign centered on the family and relationships is being developed for 1987-88. The campaign will focus on two youth health issues: teen pregnancy and motherhood, teen sex and AIDS. Public health experts have asserted that the "next wave" of high risk individuals for contracting AIDS are teens experimenting with drugs and sex.

Additional topics such as teen suicide, youth nutrition and exercise could be factored into a Phase II public campaign on family/youth health issues.

The Board approved the concept of Phase I of the 1987-88 media campaign, and agreed to consider Phase II funding during the 1988 budgeting process.

Task Force on Financial Aid to Medical Students

This is the fifth year for this Task Force activity, which has granted loans of $50,000, $75,000, $100,000, and $125,000. The total distribution of loan funds amounts to $237,009. The first loans have come due for collection and, as of July 1, all payments had been received. The Board authorized that: $175,000 be released from the Illinois State Medical Society Student Loan Fund account for the purpose of providing student loans to eight Illinois medical schools for academic year 1987-88 in the following increments (with concurrent approval by the Educational and Scientific Foundation): University of Chicago Pritzker School of Medicine, $25,145; Loyola University Stritch School of Medicine, $17,465; Rush Medical College $22,768; Chicago College of Osteopathic Medicine, $13,773; Northwestern University Medical School, $26,635; University of Illinois, $36,068; Southern Illinois University, $10,833; Chicago Medical School, $22,313.

The Board also approved a $5,000 grant for a start-up fund, advanced from the Student Loan Fund and used for fundraising activities.

Committee on Drugs and Therapeutics

The Board approved the following drug products for inclusion in the IDPA drug manual: Corzide (Nadolo-Bendroflu methiazide); Creon (Pancreatin, USP); Estraderm (Estradiol Transdermal).

The Board also recommended that the following drugs not be included in the IDPA drug manual: Advil (Ibuprofen); Buspar (Buspirone Hydrochlorine); Betadine douche; Fiberall (dietary supplement); Fiberall Wafer (dietary supplement); Humatrope (Somatropin Recombinant DNA); Novopen (insulin delivery device); Psorcon (Diflorasone Diacetate); Xanax (Alprazolam).

The Board further recommended that: (1) IDPA not include the drug products Seldane and Pramosone in the IDPA drug manual; and (2) IDPA now include Citracal in the drug manual.

Policy Committee

The Board, in keeping with previous HOD action, approved the following policy statements for inclusion in the Policy Manual:

New Policies

- Withdrawing or Withholding Life-Prolonging Treatment
- Confidentiality and Utilization Review
- Corporal Punishment in Illinois Schools
- Medical Control in Pre-Hospital Care
- Breast Cancer Screening
- Indemnification

Amended Policies

- Medical Testimony, Expert Witnesses
- Mental Health
- Emergency Medical Care, Provision of
- Eye Care
- Confidentiality
- Health Planning

Deleted Policies

- Direct Billing
- Foundations for Medical Care
- Veterans Administration
- Governmentally-Supported Health Facilities
- Dual Standard of Care
- Reimbursement
- Death with Dignity
- Examinations

In addition, upon recommendation of the Policy Committee, on their review of the Official ISMS Actions,

(continued on page 394)

Because 50% of hypertensive patients drop out in their first year[1]...



INTRODUCING HYTRIN® 1 mg 2 mg 5 mg tablets

(terazosin HCl) ONCE-A-DAY ONE PRICE

The first once-a-day alpha, blocker

FOR YEARS OF
COMPLIANCE,



NOT COMPLAINTS
IN HYPERTENSION

- **Well-tolerated, once-a-day therapy for patient compliance that lasts**

  Rarely causes • *impotence*[2] • *depression*[3] • *sleep disturbances*[3]
  Doesn't compromise • *potassium*[2] • *glucose*[2] • *lipids*[4]

- **Long-term control as initial therapy or in combination**

- **Excellent patient acceptance reduces dropouts**

  An estimated 80% of responders stay on HYTRIN long term, as shown in a two-year study[3]

  Side effects generally were mild and transient. Dizziness and asthenia were the most common. Others reported significantly more frequently than with placebo were nasal congestion, peripheral edema, somnolence, nausea, palpitations, and blurred vision. Incidence of syncope (1.0%) was not significantly different from placebo.

- **One price for all dosage strengths**

  Even if dosage is increased, patient cost is not increased

NEW HYTRIN® 1 mg 2 mg 5 mg tablets
(terazosin HCl) **ONCE-A-DAY ONE PRICE**

The first once-a-day alpha, blocker

ABBOTT Wellcome **advancing cardiovascular care**

Please see accompanying brief summary.
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HYTRIN®

(terazosin hydrochloride tablets)

Brief Summary

CLINICAL PHARMACOLOGY: Pharmacodynamics: Clinical studies of terazosin used in once-a-day (majority) and b.i.d regimens with total doses usually in the range of 5-20mg/day, in patients with mild or moderate hypertension. Because terazosin, like all alpha antagonists, can cause large falls in blood pressure after the first dose or first few doses, the initial dose was 1mg in virtually all studies, with subsequent titration to a specified fixed dose or titration to a specified blood pressure end point.

Blood pressure responses were measured at the end of the dosing interval (usually 24 hrs.) and effects were shown to persist throughout the interval, with usual supine responses 5-10mmHg systolic and 3.5-8mmHg diastolic greater than placebo. The responses in the standing position tended to be somewhat larger, although this was not true in all studies. The magnitude of blood pressure responses was similar to prazosin and less than hydrochlorothiazide (in a single study). In measurements 24 hrs. after dosing, heart rate was unchanged.

Limited measurements of peak response (2-3 hrs. after dosing) during chronic terazosin administration indicate that it is more than twice the trough (24 hr.) response, suggesting some attenuation of response at 24 hrs., presumably due to a fall in blood terazosin concentrations at the end of the dose interval. This explanation is not established with certainty and is not consistent with the similarity of blood pressure response to once-a-day and b.i.d. dosing. With the absence of an observed dose-response relationship over a range of 5-20mg, i.e., if blood concentrations fall to the point of providing less than full effect at 24 hrs., a shorter dosing interval or larger dose should lead to increased response. Measure blood pressure (BP) at the end of the dose interval; if response is not satisfactory, patients may be tried on a larger dose or b.i.d. regimen. The latter should be considered if side effects, such as dizziness, palpitations, or orthostatic complaints, are seen within a few hours after dosing.

The greater BP effect associated with peak plasma concentrations (first few hours after dosing) appears somewhat more position-dependent (greater in the erect position) than the effect of terazosin at 24 hrs. In the erect position there is a 6-10 bpm increase in heart rate in the first few hours after dosing. During the first 3 hrs. after dosing 12.5% of patients had a systolic pressure fall of 30mmHg or more from supine to standing, or standing systolic pressure below 90mmHg with a fall of at least 20mmHg, compared to 4% of a placebo group.

INDICATIONS AND USAGE: Indicated for the treatment of hypertension.

CONTRAINDICATIONS: None known.

WARNINGS: Syncope and "First-dose" Effect: Terazosin, like other alpha-adrenergic blocking agents, can cause marked hypotension, especially postural hypotension, and syncope in association with the first dose or first few doses. A similar effect may occur if therapy is interrupted for more than a few doses. Syncope has been reported with other alpha-adrenergic blocking agents in association with rapid dosage increases or introduction of another antihypertensive drug. Syncope may be due to an excessive postural hypotensive effect, although occasionally the syncopal episode has been preceded by severe supraventricular tachycardia with heart rates of 120-160 bpm.

To decrease the likelihood of syncope or excessive hypotension, always initiate treatment with a 1mg dose at bedtime. The 2mg and 5mg tablets are not indicated as initial therapy. Increase dosage slowly, and add additional antihypertensive agents with caution. Caution patients to avoid situations where injury could result if syncope occurs during initiation of therapy.

In early studies, where increasing single doses up to 7.5mg were given at 3 day intervals, tolerance to the first dose phenomenon did not necessarily develop and the "first dose" effect was observed at all doses. Syncopal episodes occurred in 3 of 14 subjects given doses of 2.5, 5, and 7.5mg, which are higher than the recommended initial dose. Severe orthostatic hypotension (BP 50/0mmHg) was seen in two others and dizziness, tachycardia, and lightheadedness occurred in most subjects. These adverse effects all occurred within 90 min. of dosing.

In multiple dose clinical trials involving nearly 2000 patients, syncope was reported in about 1% of patients, in no case severe or prolonged, and was not necessarily associated with early doses.

If syncope occurs, place patient in recumbent position and treat supportively. There is evidence that the orthostatic effect of terazosin is greater, even in chronic use, shortly after dosing.

PRECAUTIONS: *General: **Orthostatic Hypotension:*** While syncope is the most severe orthostatic effect of terazosin, other symptoms of lowered BP, such as dizziness, lightheadedness and palpitations, are more common, occurring in 28% of patients in clinical trials. Patients with occupations in which such events represent potential problems should be treated with particular caution.

Information for Patients: Make aware of possibility of syncopal and orthostatic symptoms, especially at initiation of therapy, and to avoid driving or hazardous tasks for 12 hrs. after the first dose, after a dosage increase, and after interruption of therapy when treatment is resumed. Caution to avoid situations where injury could result should syncope occur during initial therapy. Advise to sit or lie down when symptoms of lowered BP occur and to rise carefully from a sitting or lying position. Bothersome dizziness, lightheadedness, or palpitations should be reported to physician.

Tell patients that drowsiness or somnolence can occur, requiring caution in people who must drive or operate heavy machinery.

Laboratory Tests: Small but statistically significant decreases in hematocrit, hemoglobin, WBC, total protein and albumin were observed in clinical trials. The magnitude of decreases did not worsen with time. These findings suggest the possibility of hemodilution.

Drug Interactions: In controlled trials, terazosin was added to diuretics, and several beta-adrenergic blockers; no unexpected interactions were observed. Terazosin has also been used concomitantly without interaction in at least 50 patients on the following: 1) analgesic/anti-inflammatory (acetaminophen, aspirin, codeine, ibuprofen, indomethacin); 2) antibiotics (erythromycin, trimethoprim and sulfamethoxazole); 3) anticholinergic/sympathomimetics (phenylephrine HCl, phenylpropanolamine HCl, pseudoephedrine HCl); 4) antigout (allopurinol); 5) antihistamines (chlorpheniramine); 6) cardiovascular agents (atenolol, hydrochlorothiazide, methyclothiazide, propranolol); 7) corticosteroids; 8) gastrointestinal agents (antacids); 9) hypoglycemics; 10) sedatives and tranquilizers (diazepam).

Carcinogenesis, Mutagenesis, Impairment of Fertilty: HYTRIN was devoid of mutagenic potential when evaluated *in vivo* and *in vitro*.

HYTRIN, administered in feed to rats at doses of 8, 40, and 250mg/kg/day for 2 yrs., was associated with a statistically significant increase in benign adrenal medullary tumors of male rats exposed to the 250mg/kg dose. This dose is 695 X max. recommended human dose (20mg/55kg). Female rats were unaffected. HYTRIN was not oncogenic in mice when administered in feed for 2 yrs. at a maximum tolerated dose of 32mg/kg/day.

The absence of mutagenicity in a battery of tests, of tumorigenicity of any cell type in the mouse carcinogenicity assay, of increased total tumor incidence in either species, and of proliferative adrenal lesions in female rats, suggests a male rat species-specific event. Numerous other diverse pharmaceutical and chemical compounds have been associated with these tumors in male rats without supporting evidence for carcinogenicity in man.

Effects on fertility were assessed in a standard fertility/reproductive performance study in which male and female rats were administered oral doses of 8, 30 and 120mg/kg/day. Four of 20 male rats given 30mg/kg and 5 of 19 male rats given 120mg/kg failed to sire a litter. Testicular weights and morphology were unaffected. Vaginal smears at 30 and 120mg/kg/day appeared to contain less sperm than smears from control matings and good correlation was reported between sperm count and subsequent pregnancy.

Oral use for 1 or 2 yrs. elicited a statistically significant increase in testicular atrophy in rats exposed to 40 and 250mg/kg/day, but not in rats exposed to 8mg/kg/day (> 20 X max. recommended human dose). Testicular atrophy was observed in dogs dosed with 300mg/kg/day (> 800 X max. recommended human dose) for 3 months but not after 1 yr. when dosed with 20mg/kg/day. This lesion has also been seen with Minipress®.

Pregnancy: Teratogenic effects: Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women and the safety of terazosin in pregnancy has not been established. HYTRIN is not recommended during pregnancy unless potential benefit justifies potential risk to mother and fetus.

Nonteratogenic effects: In a peri- and post-natal development study in rats, significantly more pups died in the group dosed with 120mg/kg/day (> 300 X max. recommended human dose) than in the control group during the 3-week post-partum period.

Nursing Mothers: It is not known whether terazosin is excreted in breast milk; therefore, exercise caution when administering terazosin to a nursing woman.

Pediatric Use: Safety and effectiveness have not been determined.

ADVERSE REACTIONS: The prevalence of adverse reactions has been ascertained from 14 placebo-controlled studies conducted primarily in the U.S. The studies involved once-a-day administration of terazosin as monotherapy or in combination with other antihypertensive agents, at doses ranging from 1 to 40mg. All adverse events reported during these studies were recorded as adverse reactions. Adverse events where the prevalence rate in the terazosin group was at least 5%, where the prevalence rate for the terazosin group was at least 2% and was greater than the prevalence rate for the placebo group, or where the reaction is of particular interest are summarized below. Only asthenia, blurred vision, dizziness, nasal congestion, nausea, peripheral edema, palpitations and somnolence were significantly ($p < 0.05$) more common in patients receiving terazosin than in patients receiving placebo. Other events include **{%TERAZOSIN-%PLACEBO}:** asthenia (11.3%-4.3%), back pain (2.4%-1.2%), blurred vision (1.6%-0%), depression (0.3%-0.2%), dizziness (19.3%-7.5%), dyspnea (3.1%-2.4%), edema (0.9%-0.6%), headache (16.2%-15.8%), impotence (1.2%-1.4%), libido decreased (0.6%-0.2%), nasal congestion (5.9%-3.4%), nausea (4.4%-1.4%), nervousness (2.3%-1.8%), pain-extremities (3.5%-3%), palpitations (4.3%-1.2%), paresthesia (2.9%-1.4%), peripheral edema (5.5%-2.4%), postural hypotension (1.3%-0.4%), sinusitis (2.6%-1.4%), somnolence (5.4%-2.6%), tachycardia (1.9%-1.2%), weight gain (0.5%-0.2%).

Adverse reactions were usually mild or moderate in intensity but sometimes were serious enough to interrupt treatment. Adverse reactions that were most bothersome as judged by being reported as reasons for discontinuation of therapy by at least 0.5% of the terazosin group and being reported more often than in the placebo group **{%TERAZOSIN-%PLACEBO}** are: asthenia (1.6%-0%), blurred vision (0.6%-0%), dizziness (3.1%-0.4%), dyspnea (0.9%-0.6%), headache (1.3%-1%), nasal congestion (0.6%-0%), nausea (0.8%-0%), palpitations (1.4%-0.2%), paresthesia (0.8%-0.2%), peripheral edema (0.6%-0%), postural hypotension (0.5%-0%), somnolence (0.6%-0.2%), syncope (0.5%-0.2%), tachycardia (0.6%-0%).

Additional adverse reactions have been reported, but these are not distinguishable from symptoms that might have occurred in the absence of exposure to terazosin. The following additional adverse reactions were reported by at least 1% of 1987 patients who received terazosin in clinical studies or during marketing experience: abdominal pain, abnormal vision, anxiety, arrhythmia, arthralgia, arthritis, bronchitis, chest pain, cold symptoms, conjunctivitis, constipation, diarrhea, dry mouth, dyspepsia, epistaxis, facial edema, fever, flatulence, flu symptoms, gout, increased cough, insomnia, joint disorder, myalgia, neck pain, pharyngitis, pruritus, rash, rhinitis, shoulder pain, sweating, tinnitus, urinary frequency, urinary tract infection, vasodilation, vomiting.

DOSAGE AND ADMINISTRATION: Dose and dose interval (12 or 24 hrs.) should be adjusted according to BP response.

Initial Dose: 1mg at bedtime. Observe the initial dosing regimen strictly to minimize potential for severe hypotensive effects.

Subsequent Doses: Slowly increase dose to achieve desired BP response. Usual dose range is 1mg to 5mg once a day. Some patients may benefit from doses up to 20mg/day. Doses over 20mg do not appear to provide further BP effect. Doses over 40mg have not been studied. Monitor BP at the end of dosing interval to assure control is maintained. It may be helpful to measure BP 2-3 hrs. after dosing to see if maximum and minimum responses are similar, and to evaluate symptoms which can result from excessive hypotensive response. If response is substantially diminished at 24 hrs. consider an increased dose or b.i.d. regimen. **If administration is discontinued for several days or longer, reinstitute therapy using initial dosing regimen.** In clinical trials, except for the initial dose, the dose was given in the morning.

Use With Other Drugs: Caution should be observed when terazosin is administered concomitantly with other antihypertensive agents (e.g., calcium antagonists) to avoid the possibility of significant hypotension. When adding a diuretic or other antihypertensive agent, dosage reduction and retitration may be necessary.

August, 1987 **Abbott Health Care Products, Inc.** North Chicago, IL 60064 7083834

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1. Burell CD, Levy RA: Therapeutic consequences of noncompliance, in: *Improving Medication Compliance: Proceedings from a Symposium*. Reston, VA, National Pharmaceutical Council, 1984, pp 7-16.
2. Sperzel WD, Glassman HN, Jordan DC, et al: Overall safety of terazosin as an antihypertensive agent. *Am J Med* 1986;80(suppl 5B):77-81.
3. Data on file, Abbott Pharmaceuticals.
4. Deger G: Effect of terazosin on serum lipids. *Am J Med* 1986;80 (suppl 5B):82-85. 7083834

OBITUARIES

***Griffin, William D.,** Peoria, died September 6, 1987 at the age of 71. Dr. Griffin was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Gumbiner, Bernard,** Northbrook, died September 25, 1987 at the age of 75. Dr. Gumbiner was a 1937 graduate of Northwestern University Medical School, Chicago.

****Lespinasse, Victoire D.,** Elgin, died September 20, 1987 at the age of 77. Dr. Lespinasse was a 1936 graduate of Northwestern University Medical School, Chicago.

****McVety, T. Wilson,** Decatur, died August 19, 1987 at the age of 81. Dr. McVety was a 1936 graduate of the Washington University School of Medicine, St. Louis.

****Murphy, Edward S.,** Dixon, died September 14, 1987 at the age of 77. Dr. Murphy was a 1936 graduate of Rush Medical College, Chicago.

****Olander, George A.,** Lake Forest, died September 12, 1987 at the age of 69. Dr. Olander was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

****Parisi, Patrick,** Chicago Heights, died September 3, 1987 at the age of 77. Dr. Parisi was a 1936 graduate of the University of Health Sciences/Chicago Medical School.

****Sawyer, Preston W.,** Bourbonnais, died August 31, 1987 at the age of 76. Dr. Sawyer was a 1937 graduate of the University of Illinois College of Medicine, Chicago.

Skiles, James H. Jr., Oak Park, died September 14, 1987 at the age of 74. Dr. Skiles was a 1938 graduate of Northwestern University Medical School, Chicago.

***Wilbur, David G.,** Mattoon, died September 15, 1987 at the age of 63. Dr. Wilbur was a 1947 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates members of ISMS Fifty Year Club* ◀

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

What Are Your Odds?

Evaluating Capitation Payments

When you sign a capitation contract, what are the odds that you can break even or make a profit? Are the odds in your favor or stacked against you? Evaluating payment in a capitation contract has been compared to learning how to play a game of chance. In roulette and in contracting, it's important to know the rules.

Capitation fees, risk sharing and incentive pools and payments are hallmarks of HMOs. Although incentive arrangements are as numerous as the HMOs themselves, their purposes are identical: to provide an economic incentive for physicians to make cost effective medical decisions.

How are Risk Sharing and Incentive Pools Created?

If you belong to an IPA, the IPA member physicians generally make up the pool. If you are under contract with an HMO as an individual physician, your contract probably provides that your pool will consist of a "network" of physicians. The physicians in your "network" may be grouped according to hospital affiliation or geographic location. You may be allowed to form your own "network" with physicians you know. Or the contract may give the HMO complete discretion in establishing the pool according to unstated criteria and allow the HMO to change what "network" you're in without your consent.

Where Does the Money Come From?

A group of physicians has been established to share the risks and the incentives to practice cost effective, good quality medicine. Generally speaking, the pool is funded from a percentage of your capitation payment or your discounted fee that is withheld by the HMO.

Are the withheld funds kept in an interest bearing, non-transferable account under physician control? Can the HMO increase the percentage withheld under particular circumstances? Is your consent required?

Is the Withheld Amount Refunded to You?

Generally speaking, whether you receive all, a portion, or none of your share back depends on the overall performance of your group of physicians. Group performance is most often measured against a target utilization budget for hospital, specialist physician and ancillary services.

For example, the HMO may withhold 20% of the capitation due primary care physicians in a pool. It has also established a target utilization budget fund based upon its assumption of what the anticipated costs of referral, hospital and ancillary services will be. If its target fund is inadequate to pay for these services, then the withheld amount is used to pay for overruns. If money is left in the physician pool, it may be distributed to the primary care physician in proportion to the physician's contribution to the pool. Even if there is a distribution from the fund, some contracts provide that a physician may be barred from receiving his or her share if it is determined that the physician has exceeded HMO-established norms regarding utilization.

Are You Liable for Deficits?

Suppose the utilization of hospital, specialist and ancillary services of your group exceeded the "target" budget and a deficit still existed after your group's withheld

money was used. Are you liable for the deficit? It depends upon your contract. Some contracts make you liable for a percentage of the deficits, while others require that the HMO pay deficits which exist after withheld funds have been exhausted. Likewise, if there is a surplus in the targeted budget, the HMO may be required to share the surplus with your group and you may receive your withheld amount back. Distribution of withheld funds from an IPA to its member physicians may be controlled by the IPA board of directors and may depend on the financial condition of the IPA.

Sometimes an IPA's incentive to practice cost effective good quality medicine is a direct payment to the IPA based on the savings that occur if the actual hospital days utilized are less than the HMO's projected hospital utilization figure. The critical question in any incentive arrangement is whether the target budget or the utilization projection is realistic and consistent with good medical practices. (See *The Informed Physician:* "Weighing the Odds," October *IMJ.*)

How Do You Know What is Due You?

Some contracts provide that the HMO will supply a statement of the credits and liabilities of your pool. Will the statement be provided quarterly or on an annual basis? The statement may be useful, but do you have the right to audit the HMO books and claims records? Perhaps the HMO mistakenly made inappropriate charges against the target budget or even made duplicate charges so your withheld funds were used inappropriately. Some contracts provide for reasonable audits. However, if you accept the payment of the withheld funds due, some contracts make this acceptance equivalent to acceptance that the payment amount is accurate. In that instance, it operates as a waiver of your right to audit.

Does the Contract Provide for Reinsurance to Protect You From Catastrophic, Unlimited Losses?

In HMO contracts, reinsurance is frequently referred to as stop-loss insurance. Stop-loss insurance sets a maximum amount (the threshold) after which you are not responsible for claims. Such insurance is extremely important because it may be expected that no HMO or IPA will be without its catastrophic cases.

A stop-loss provision may look like this: "HMO shall provide stop-loss insurance to IPA so that any billings for covered services totaling more than $5000 for any one subscriber for any year will be paid for from a reinsurance policy." The threshold amounts vary depending on the policy. Sometimes the coverage is not per subscriber per year, but per subscriber per illness per year. What services are covered in order to reach to stop-loss threshold? What dollar amount is placed on each service in calculating the threshold amount? Are fees discounted? Is the usual and customary charge used or the actual charge for the service? What services are covered after the threshold amount is reached and what is the percentage of coverage?

Because you're an informed physician who recognizes the complexity of these contracts, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you objective comments on any HMO, PPO, or IPA contract. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful review and reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

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The only patch with a rate-limiting membrane

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All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.

CIBA

629-3468-A

(See Brief Summary of Prescribing Information on the next page.)

*Data on file, CIBA Pharmaceutical Co.

Transderm-Nitro® nitroglycerin
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area.
Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm²	30 Systems...NDC 0083-2025-26
			*30 Systems...NDC 0083-2025-26
			*100 Systems...NDC 0083-2025-30
5 mg/24 hr	25 mg	10 cm²	30 Systems...NDC 0083-2105-26
			*30 Systems...NDC 0083-2105-26
			*100 Systems...NDC 0083-2105-30
10 mg/24 hr	50 mg	20 cm²	30 Systems...NDC 0083-2110-26
			*30 Systems...NDC 0083-2110-26
			*100 Systems...NDC 0083-2110-30
15 mg/24 hr	75 mg	30 cm²	30 Systems...NDC 0083-2115-26
			*30 Systems...NDC 0083-2115-26
			*100 Systems...NDC 0083-2115-30

*Institutional Pack

C87-23 (Rev. 7/87)

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Here Today. Here Tomorrow.

Today, most commercial professional liability insurers have abandoned the Illinois market. But there's still one company writing malpractice coverage up to $2 million per incident with a $4 million aggregate—the Illinois State Medical Inter-Insurance Exchange.

The Exchange is the only malpractice insurer in Illinois that is owned and operated by physicians. As such, we are totally committed to meeting the insurance needs of our policyholders. And we intend to be there as long as they need us.

Despite the recent explosion in medical malpractice litigation, the Exchange remains in good shape financially. Much of our success can be attributed to the willingness of the company's physician directors to make tough decisions—decisions like the switch to a "claims-made" policy form... the setting of adequate premium levels... and the strengthening of standards for renewing coverage and accepting new policyholders.

In the continually changing liability climate, the Exchange's directors will continue to make the sound business decisions necessary to ensure the company's long-term financial stability. But as physicians themselves, they also will be making those decisions from a policyholder's perspective. And that will translate into the best possible insurance coverage available, including...

...aggressive defense of frivolous claims;

...policyholder participation in any decision to settle a claim or suit;

...peer review of an adverse underwriting or claim decision;

...help for policyholders in avoiding the situations that can lead to suits; and

...premium rates that fairly reflect the risks inherent to the physician's own practice.

As a company owned and operated by physicians, the Exchange exists solely for the benefit of its policyholders. Some 9,000 physicians in Illinois are depending upon us. And we don't intend to let them down.

ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE

Illinois State Medical Inter-Insurance Exchange
Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602
(312) 782-2749
(800) 782-ISMS
(Toll-Free)

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

December

Cardiology

New Management Choices in Cardiology: Controversies and Otherwise

For: Physicians and other health professionals. Conference, December 4, Madison, WI. **Sponsor:** University of Wisconsin-Madison, 465A WARF Building, 610 Walnut Street, Madison, WI 53705. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category: 1: 7 hours, AOA Category 2-D and University of Wisconsin CEU's. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Advances in Aortic and Mitral Stenosis.

For: Cardiologists. Course, December 11-12, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: To be determined. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

General Medicine

Symposium on the Prevention and Treatment of Pressure Ulcers.

For: Family practitioners, dermatologists, geriatrics. Symposium, December 12-13, Oakbrook, IL. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: To be determined. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

New Concepts in Treatment of Seizures and Epilepsy

For: Interested Physicians. Lecture, December 1, DeKalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Neurology

Neurology for the Non-Neurologist.

For: Family practitioners, internists, psychiatrists. Lecture/workshop, December 9-11. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago. **Fee:** $400. **Reg. Limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Office of Continuing Education. **Phone:** (312) 942-7095.

Obstetrics and Gynecology

Problem Solving in Gynecologic Endocrinology & Infertility

For: Obstetricians, gynecologists. Course, December 11-12, The Knickerbocker Hotel, Chicago. **Sponsor:** The University of Chicago School of Medicine, 5841 S. Maryland, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Endometriosis

For: Gynecologists. Lecture, December 15, De Kalb. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Pathology

Seminar on Fine Needle Aspiration

For: Pathologists. Seminar, December 13, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central, Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5716.

Urology/Radiology/Pathology

Urologic Pathology and Radiology

For: Urologists, pathologists, and radiologists. Lecture, December 7-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800)621-4649; outside Illinois: (800) 621-4651.

JANUARY

Internal Medicine/Family Practice/GP

AIDS: Role of the Practitioner

For: Interested physicians. Symposium, January 26, Drake Hotel, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611, ISMS and AMA. **Fee:** $40. Reg. Limit: 200. **Credit:** Category 1: 3 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Year in Internal Medicine

For: Interested physicians. Course, January 27-29, Drake Hotel, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611, ISMS and AMA. **Fee:** $275. Reg. Limit: 300. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cellular Mechanisms of Insulin Action-Diabetes Mellitus

For: Interested Physicians. Lecture, January 11, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central, Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5716.

February

Psychiatry

The Psychiatric Interview

For: Psychiatrists. Course, February 26-28, Holiday Inn, Mart Plaza, Chicago. **Sponsor:** University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** 150. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

CARAFATE® (sucralfate)

BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 62-69, 1984

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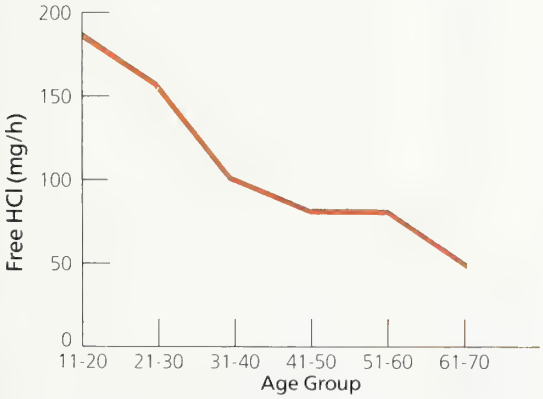
Specialized ulcer therapy

When advancing age signals reduced acid secretion



If your duodenal ulcer patient is over 55, decreased mucosal resistance is more likely to cause an ulcer than hypersecretion of acid-pepsin.[1] A tendency toward lower acid secretion with advancing age has been shown.[2,3]

Declining gastric secretion and age[3]



CARAFATE® (sucralfate/Marion) makes sense as initial ulcer therapy for the elderly. Carafate provides ulcer healing rates comparable to H_2 antagonists without the risk of systemic side effects or drug interactions—an important benefit for older patients.

The unique, nonsystemic action of Carafate enhances the body's own ulcer healing ability, strengthening the mucosal structure as it protects damaged tissue from further injury.

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Please see adjoining page for references and brief summary of prescribing information

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Benefits and Drawbacks

Hold Harmless Agreements

A number of our members have encountered difficulties arising from "hold harmless" agreements issued by third party payors. These most often take the form of letters sent to patients by third party payors suggesting that physician fees in excess of a "reasonable" charge defined by the third party should not be paid.

In fact, they have in some cases suggested that if the patient is sued for these physician fees, the payer will defend him or her in court, and indemnify the patient for all resulting costs.

This article seeks to identify means to cope with a difficult and awkward situation. It is not designed or intended to substitute for the advice of legal counsel.

Recently, efforts to effect payment have been known to affect the physician-patient relationship with respect to reimbursement. Certain entities have sought to limit physician charges by attempting to mandate that reimbursement levels from insurers and other third party payors should constitute full and total compensation.

This may at times come about regardless of any agreements the physician may, or may not, have had with the third party payor or the patient.

If a physician agrees in advance to accept a third party payor's reimbursement as payment in full, then he or she is precluded by contract from seeking additional compensation.

Where the physician has not signed such agreements with third party payors, some third party payors have reinforced their insureds' efforts to avoid paying the difference between usual and customary fees and reimbursement levels. For example, payors have offered to defend the patient in any legal action ultimately brought by a physician seeking additional compensation.

However, absent a specific agreement to the contrary, there is no automatic legal limitation on the physician's right to bill his or her patient directly for usual and customary charges unpaid by the insurer or third party other than in some government paid programs. Where the physician has not entered into such an agreement with either a third party payor or a patient, and a third party payor challenges physician charges on behalf of a beneficiary, the courts must determine whether the charges are "reasonable."

This is not, legally speaking, the same as "prevailing and customary," since the prevailing and customary charges in a locality may be unreasonable. But for practical purposes, the court would probably find as "reasonable" those medical charges which tend to prevail in the locality.

If a signed physician-patient contract incorporates either the charges for the specific services rendered or an entire fee schedule, and those fees are challenged, the court will apply not a "reasonable" standard, but the higher standard of "unconscionability." This is a much more difficult standard for the challengers of a physician's fee to reach. The court must find both that the parties were mismatched in terms of bargaining power (so as to make meaningful negotiations impossible), and also that the resultant agreement is unconscionably favorable to the dominant party. Physicians clearly have a significantly strengthened legal position in defense of fees under such a physician-patient contract.

Each case must be viewed individually in order to find an appropriate course of action and define the extent to which a third party payor can affect the physician/patient relationship. Because each case must be viewed on its own merits, the Illinois State Medical Society cannot, and does not, offer any legal advice or advocate any policy for dealing with these situations. Legal advice can only be given by your individual legal advisor, with whom you may wish to discuss these matters.

However, physicians may wish to consider the creation of a contract between themselves and the patient outlining the terms and conditions

of the services to be provided by the physician and the compensation to be received. If a physician were to decide to create such a document for his or her patients, the adjacent sidebar could be used as an example (see box). This example is presented for informational purposes only. It should be tailored to your specific needs and conditions in consultation with your legal advisor and discussion with your patients. It is not proposed as a policy of the Illinois State Medical Society.

The sample document makes it clear that the physician-patient relationship is a contractual one which cannot be affected by third parties unless both the physician and the patient agree to be bound by the dictates of that third party.

Incorporating Specific Charges

Placing the specific charges which will apply to the patient within the body of the document ensures that the patient knows and understands the specific dollar charges in advance, and would be less likely to question them later. Such a document also clearly demonstrates to third parties that there is an agreement between the physician and the patient, that the patient knows the essence of that agreement (*e.g.*, the physician's fees), and knows the agreed fees.

The example shown is applicable to providing a specific service. If it is desirable to have an agreement for ongoing care, the physician may wish to insert normal fees for each anticipated service and state that the agreement is ongoing.

A variation on this would be to incorporate the entire fee schedule in the agreement. The patient would then be put on notice that the attached or incorporated fee schedule is what he or she agrees to pay when such services are delivered. If the physician takes this approach, the bill sent to the patient should be itemized in sufficient detail to allow comparison to the fee schedule.

The major benefit of a physician-patient agreement which incorporates the full range of physician charges is that it avoids the administrative/clerical problems of a different contract for each patient (or at least each patient covered by a third party payor). It also avoids the possibility that the third party payor might contest any charges for services rendered that did not appear in the "individualized" physician-patient contract.

Incorporating the physician's entire fee schedule into the contract is not entirely uncomplicated. For example, a court may then treat the contract as a "contract by adhesion." A "contract by adhesion" is one that a party in a superior position presents as a whole to the other party for acceptance or rejection. Contracts for insurance, with their incorporated schedules, usually fall into this category. When a contract is treated as a "contract by adhesion," having been written by one party and presented as a whole to the other party, the courts will resolve ambiguities in favor of the "adhering" party. This is based on the notion that the drafting party must bear the burden for any ambiguities or mistakes. If the physician chooses to incorporate the entire fee schedule into a physician-patient contract, great care must be taken in its drafting.

Moreover, the physician must balance the competing interests of economics and smooth physician-patient relationships. On the one hand, a physician-patient contract can eliminate the limitations potentially imposed by a third party payor's "hold harmless" agreement. On the other hand, a physician with few patients who are members of health plans trying to impose "hold harmless" agreements may find that the benefits to be gained in the un-

Agreement

_____, M.D. and _____, patient, agree that _____, M.D. will provide medical care and treatment as needed to _____ under such terms and conditions as are generally afforded to patients of _____, M.D., in need of medical care. Such care shall be rendered at times and locations deemed necessary or appropriate by the parties.

Patient understands that to the extent he or she has health insurance or receives compensation from a third party as a health benefit, that contract is between the patient and their insurer or employer and does not affect the relationship and responsibilities of the patient to the physician unless the physician has separately agreed to be bound by those terms.

Patient agrees that in the event he or she fails to pay all the charges incurred in connection with medical treatment received from Dr. _____, and legal action becomes necessary, patient will be liable for all court costs and reasonable attorneys' fees incurred by Dr. _____ in the collection of this account.

I, (patient's name), hereby acknowledge that I have read the foregoing explanation of my payment obligation to the office of Dr. _____ for charges incurred in connection with my medical care, and further acknowledge that said terms have been explained to me and I understand them and agree to be bound thereby.

common individual situation are outweighed by the added administrative burden and the potential friction introduced in the physician-patient relationship.

If only a few patients in the physician's total practice are members of health plans which are attempting to impose such "hold harmless" agreements, the physician must decide whether to ask only those patients to sign physician-patient agreements, which represents some degree of clerical burden, or to do such physician-patient contracts for all patients. In the latter case, not only would much of the effort be wasted, but some patients might protest. A concomitant increase in friction in the physician-patient relationship could result.

Finally, this kind of physician-patient agreement cannot affect reimbursement under the Medicare and Medicaid programs because such reimbursement schemes are governed by federal and state statutes and program regulations.

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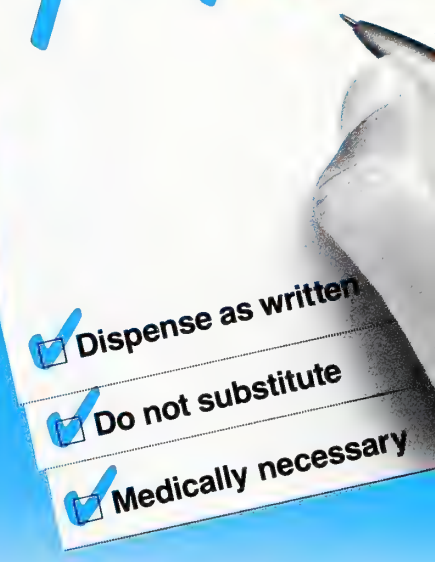
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In Patients with Co-Existing Pancreatitis

Surgery for Primary Hyperparathyroidism

By William A. Zamboni, M.D., Donald S. Ross, M.D., John W. Oren, M.D. Jacobo Wortsman, M.D., and J. Roland Folse, M.D./Springfield

The effect of surgical treatment for primary hyperparathyroidism in patients with co-existing pancreatitis has not been adequately established. Four cases of pancreatitis (three acute and one chronic) among 82 patients (4.9%) with surgically-confirmed primary hyperparathyroidism were reviewed together with 66 additional cases collected from medical literature. Surgical cure of the hyperparathyroidism resolved or improved pancreatitis in 44 of 70 patients (63%), demonstrating a more effective improvement rate for acute (23 of 30 patients, 77%) vs. chronic pancreatitis (21 of 40 patients, 53%).

Neck exploration was associated with minimal operative morbidity or mortality in either acute or chronic pancreatitis. In patients with acute pancreatitis, the time from admission to diagnosis and treatment of associated primary hyperparathyroidism was surprisingly long (23 ± 4 days), indicating a need for earlier diagnosis and neck exploration. It is concluded that surgery of associated primary hyperparathyroidism is a safe procedure that may result in a shorter hospital stay and decreased morbidity from acute pancreatitis.

It has been suggested that acute pancreatitis is often associated with or precipitated by primary hyperparathyroidism. Also indicated is that pancreatitis frequently remits following surgical treatment of the hyperparathyroidism.[1,2] Some epidemiologic studies, however, negate the existence of a true association between these conditions,[3-5] and question the benefit of parathyroid surgery upon the course of pancreatitis.[5] Since surgical procedures are potentially dangerous in acute pancreatitis,[6] there is a need to better define the role of parathyroidectomy in these patients.[7,8] This paper is an evaluation of four patients with severe pancreatitis and primary hyperparathyroidism. In addition, the medical literature was reviewed and analyzed jointly with the local experience.

Case Report

A 27-year-old white male presented with a two-week history of severe abdominal pain and elevated serum amylase concentration, consistent with pancreatitis. He was admitted to an outlying hospital and treated with bowel rest and total parenteral nutrition. Because he did not respond to medical treatment, the patient was transferred to one of our affiliated hospitals.

On admission, the patient complained of severe abdominal pain associated with nausea. Past history was remarkable for moderate alcohol intake. Physical examination revealed a thin young man in distress from abdominal pain. Rectal temperature was 37.5° C, blood pressure 180/100mmHg, pulse 125 beats per minute and regular. Examination revealed diffuse abdominal tenderness, most severe in the mid-abdomen. Bowel sounds were absent. Laboratory values on admission revealed a white blood cell count of 17,400, serum amylase 143IU/L (normal 23-85) and serum lipase 40IU/L (normal 4-24).

Serum calcium was 14.2mg/dl (normal 8.5-10.5) and serum phosphate was 1.8mg/dl (normal 2.5-4.5).

Hospital course was characterized by progressive worsening of the patient's general condition. On the fifth hospital day, the patient developed peritoneal signs and fever to 39.0°C. An abdominal CT scan (Figure 1) followed by exploratory laparotomy revealed a ruptured pancreatic pseudocyst. Palpation of the gallbladder revealed no stones, and a cholecystostomy, gastrostomy, feeding jejunostomy and sump drainage of the lesser sac and subhepatic space were performed. Postoperatively, the patient's condition continued to deteriorate with persistent abdominal pain and leukocytosis. Serum calcium remained elevated, ranging from 11-12.5mg/dl and serum parathyroid hormone was 0.7mg/ml (normal 0.6-1.3). On the eighteenth day a parathyroid adenoma was excised from the right superior gland. (Figure 2)

The patient made rapid clinical improvement; abdominal pain and white blood cell count decreased. He was discharged two months after admission with no abdominal pain and with normal biochemical parameters. One year later he remained asymptomatic and had gained 10kg in weight.

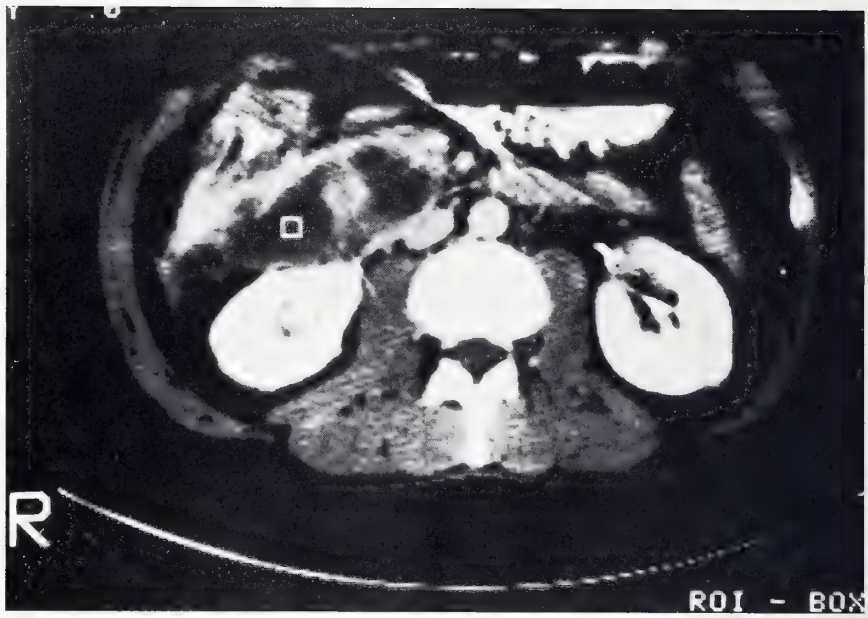


Figure 1
Abdominal CT scan demonstrating fluid densities (square) in the head of the pancreas.



Figure 2
Operative photograph showing the large right superior parathyroid adenoma (forceps) at neck exploration.

Methods

The records of patients with primary hyperparathyroidism seen at two hospitals affiliated with our institution were reviewed from 1972 to 1984. Criteria for inclusion in the study were as follows: (1) Pathologic confirmation of parathyroid abnormality; (2) Pancreatitis defined as either (a) abdominal pain plus elevated serum amylase, (b) abdominal pain plus laboratory profile consistent with biliary obstruction in the absence of cholelithiasis and/or (c) demonstration of pancreatitis at surgery/autopsy; and (3) Description of the clinical course following parathyroid surgery. Pancreatitis was considered acute if abdominal pain was present for less than six months, and chronic if present for over six months.

Results

A total of four cases of pancreatitis among 82 consecutive cases (4.9%) of surgically and pathologically confirmed primary hyperparathyroidism was collected from our institution and affiliated hospitals. Ages were 27, 32, 45 and 59 years; three were male and one was a female. The pancreatitis was acute in three subjects and chronic in one. One patient had a history of moderate alcohol intake; none had evidence of active biliary disease at the time of admission.

All four patients presented with hypercalcemia and two had hypophosphatemia. PTH concentrations were elevated in only two of them. Three patients had prior cholecystectomy, two had a history of peptic ulcer disease, and one had nephrolithiasis. One patient, who had chronic pancreatitis for many years, had additional manifestations of primary hyperparathyroidism (cholelithiasis, nephrolithiasis and peptic ulcer). Histologic examination of the parathyroid glands revealed an adenoma in all four patients.

Following parathyroid surgery, serum calcium became normal, and the symptoms of acute pancreatitis resolved. The patient with chronic pancreatitis required further hospitalization for recurrent abdominal pain after cure of the hyperparathyroidism. Follow-up ranged from one to five years (mean: 26 months).

Discussion

The controversy regarding the relationship between pancreatitis and primary hyperparathyroidism stems from the wide range of reported incidences. Early reports noted a high incidence of pancreatitis (7%-12%) among patients with hyperparathyroidism.[1,2] More recently however, several authors have reported low incidences.[3,5,6] In the largest of these series,[3] pancreatitis was found in only 17 of 1153 patients (1.5%) with surgically confirmed primary hyperparathyroidism, leading to the suggestion that the association may be more apparent than real. At this institution the incidence was 4.9%, similar to the incidences of 4% and 3.4% found by Kelly, *et al.*,[9] and Paloyan, *et al.*,[10] among a total of 418 patients with primary hyperparathyroidism.

It is likely that lower incidences of pancreatitis reflect the inclusion of early, asymptomatic primary hyperparathyroidism. Thus, relative incidence alone may not be a valid criterion to determine or exclude an etiological relationship between pancreatitis and hyperparathyroidism. Critical evaluation of the therapeutic response of pancreatitis to parathyroid surgery is probably a better means of determining a presumptive connection between the two disease states.

Based on the criteria defined previously in this article, a total of 66 cases of pancreatitis associated with primary hyperparathyroidism[1,2,10-32] were collected from the literature, to which we added our own four cases. Surgical therapy of hyperparathyroidism was followed by complete resolution or improvement of pancreatitis in 63% of cases (40 of the 70 patients). Acute pancreatitis had a significantly higher improvement rate of 77% (23 of 30 cases) when compared with a 53% rate (21 of 40 cases) in chronic pancreatitis.

The mean hospital stay for patients with acute pancreatitis and hyperparathyroidism was 40 ± 6 days. This is subdivided into 23 ± 4 days from admission with pancreatitis to parathyroid surgery, and 16 ± 4 days from parathyroid surgery to discharge. Although the overall mortality was 27% (19 deaths in 70 patients), it should be noted that 18 of the 19 deaths occurred prior to 1970. (Table 1) There were no deaths among the 17 patients undergoing parathyroid surgery during acute pancreatitis after 1970, and there was one death among nine patients with chronic pancreatitis during the same period for an overall mortality of four percent. By comparison, the mortality from acute pancreatitis not associated with primary hyperparathyroidism at this institution after 1970 was 7.6% (36 of 471 consecutive patients).

Table 1
Decreased Operative Mortality After 1970 in Patients with Pancreatitis and Primary Hyperparathyroidism

Type of Pancreatitis	Patients	Number of Deaths
Acute		
1962-70	13	7
1971-84	17	0
Chronic		
1962-70	31	11
1971-84	9	1

The present results demonstrate an excellent response of acute pancreatitis to surgical treatment of primary hyperparathyroidism. Although a non-operative group was not available for comparison, it is likely that the pancreatitis would persist or recur secondary to continued stimulation by the parathyroid abnormality. Despite the favorable response following parathyroidectomy, however, diagnosis and cure of primary hyperparathyroidism is rarely accomplished early in the course of acute pancreatitis (mean 23 ± 4 days), increasing morbidity from this condition. Since surgery for hyperparathyroidism does not appear to increase the operative mortality from acute pancreatitis, early neck exploration should be given a high priority in this situation. When pancreatitis has reached the chronic stage, the response to parathyroidectomy seems to be less favorable, probably because irreversible pancreatic injury has already occurred.

In conclusion, any patient presenting with pancreatitis and a normal or elevated serum calcium level should be suspected of having associated primary hyperparathyroidism. Early neck exploration in this subset of patients can be performed safely, and should resolve the pancreatitis in most cases, resulting in decreased morbidity. ◀

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References

A complete list of references for "Surgery for Primary Hyperparathyroidism" may be obtained by writing to the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

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Diagnostic Implications

Colorectal Carcinomas

By Gary G. Ghahremani, M.D., David P. Winchester, M.D., And Kambiz Dowlatshahi, M.D./Evanston & Chicago

Colorectal cancer in the United States has continued to increase, despite improved methods of diagnosis and treatment. Furthermore, a remarkable shift has occurred in the distribution of carcinomas within various anatomic segments of the large bowel. Tumors of the proximal colon have become much more frequent, whereas the rectal and rectosigmoid malignancies have declined. We reviewed 2,202 cases of primary colorectal carcinoma which were detected at two major teaching hospitals in the Chicago metropolitan area. The location and percentage of 887 tumors diagnosed during a recent five-year period (1980-84) were then compared with those of the preceding two decades. Our study showed a 10% increase of the cecal and ascending colon cancers, as well as a 12%-15% reduction in distal large bowel tumors. At this writing, both the most proximal and distal 20-25cm of the large bowel each contain about 25% of the lesions. Based on data presented here, the classic medical dictum that up to 75% of colorectal tumors are detectable by digital examination or proctosigmoidoscopy is no longer valid. With the documented increase of the proximal colonic cancer and polyps, accurate diagnosis will depend upon barium enema or colonoscopy.

Carcinoma of the large bowel continues to be a formidable public health problem in the United States. Recent data from the American Cancer Society indicate that 140,000 new cases will have been diagnosed in 1986 while 60,000 patients will succumb to this malignancy. In Illinois, approximately 7,300 individuals develop colorectal cancer and 3,200 die from it each year.[1]

In contrast to a remarkable decline of gastric carcinoma during the past five decades, there has been a progressive increase in the occurrence rate of colon cancer among Americans; it now represents the second most frequent invasive tumor in both men and women combined.[2] Experimental and clinical investigations have demonstrated causal relationships to the high fat and low fiber content of the American diet, as well as the carcinogenic effects of excreted bile upon the mucosa of the large intestine.[3-5] In this context, postcholecystectomy patients were found to have a substantially higher risk for development of carcinoma on the right side of the colon.[6,7]

Furthermore, recent studies have shown a significant change in the distribution of tumors within various anatomic segments of the colon. An increasing frequency of proximal colon cancers and a declining percentage of rectal carcinomas have been observed in several states.[8-12] However, this was not documented previously among the residents of Illinois. The hereinreported multi-institutional data confirm that such a left-to-right shift in colorectal cancer sites has also occurred in the Chicago metropolitan area during the past 25 years. The results of our study further indicate an urgent need for revision of a widely-held concept that nearly half of the tumors of the large bowel are detectable by digital examination, and up to 75% can be reached during proctosigmoidoscopy.[13-15] This classic medical teaching is no longer accurate and a new approach toward early diagnosis of colorectal carcinomas should be adopted.

Material and Methods

A retrospective study was conducted on 1694 patients with primary carcinoma of the colon and rectum who were first diagnosed and treated at University of Chicago hospitals during a 25-year period starting January 1, 1960 and ending December 31, 1984. The anatomic location of the tumor in each case was determined by preoperative barium enema, surgical or patho-

logical reports. Based on International Classification of Diseases (World Health Organization, 1976), cancer sites within the large bowel are separated into seven segments: the cecum, ascending colon, transverse colon, descending colon, sigmoid, rectosigmoid, and the rectum. Patients with anal, perianal, cloacogenic and appendiceal carcinomas, as well as tumors complicating chronic ulcerative colitis or familial polyposis syndromes, were excluded from this series.

The colorectal cancer cases were divided into three groups according to the date of initial diagnosis: first decade covering 1960-69 (746 patients), second decade covering 1970-79 (569 patients), and the most recent, a five-year interval from January 1980 through December 1984 (379 patients).

The same criteria for patient selection and tabulation of cancer sites were applied to collect comparative data from the Evanston Hospital-Northwestern University McGaw Medical Center in Evanston. A total of 508 patients with primary colorectal carcinoma were included in this evaluation. All were diagnosed and treated during a recent five-year period ending December 31, 1984.

Results

Statistical data concerning the incidence and distribution of 2,202 primary carcinomas within various segments of the large bowel were summarized.

Results show that 39.9% of 746 carcinomas detected between 1960 and 1969 were located in the rectum and rectosigmoid junction. A decade later, however, this percentage was reduced to 32.7%, and further declined to 24.1% during the 1980-84 interval. Accordingly, a statistically significant 15.8% decrease in distal colon cancers has occurred over the past quarter century. At the same time, however, there has been a relative increase in carcinomas of the cecum and ascending colon. These two areas harbored only 17.5% of large bowel carcinomas diagnosed during 1960-69, but their share increased to 23.4% during the subsequent decade and to 27.6% during the five year period (1980-84). This reflects a relative increase of 10.1% for cecal and ascending colon cancers in the course of the past 25 years. Less dramatic changes were noted in the distribution of cancers occurring elsewhere in the large intestine. Carcinomas of the transverse colon increased from 11.9% to 14.2%, and those of the sigmoid colon from 24.8% to 29.3%. Descending colon cancers declined only slightly from 5.9% to 4.8%.

The above-noted left-to-right shift in the distribution of colorectal cancers was also evident from the series of patients evaluated at Evanston Hospital. Among 508 such tumors diagnosed at that institution during 1980 to 1984, a total of 140 (27.6%) were situated in the rectum and rectosigmoid. More importantly, an almost equal number and percentage of cancers were located in the cecum and ascending colon.

It should be noted that a substantially-larger series of patients with primary colorectal cancer were first diagnosed and treated during the recent five year period at Evanston Hospital, compared to the University of Chicago hospitals' series for the same period. Nevertheless, data concerning anatomic distribution of the large bowel cancers were quite similar for both institutions, which serve two separate regions within the Chicago metropolitan area. Accordingly, the observed left-to-right shift in cancer distribution within the colon represents a general phenomenon rather than an incidental finding unique to any particular teaching hospital.

Discussion

Until three decades ago the majority of large bowel carcinomas occurred in the rectum and sigmoid. This led to the widely-held concept that digital examination can detect nearly half of all colon cancers, while up to 75% may be identified during proctosigmoidoscopy.[13,14] This is no longer accurate, as is evident from the data presented here, as well as other recent reports in the literature.[8-12,15]

Our study shows that over the past 25 years the relative incidence of rectal and rectosigmoid cancer has declined by 15.8%; these two segments now harbor only 24%-28% of all colon carcinomas. On the other hand, the incidence of cecal and ascending colon tumors has increased steadily to a new level of 27.6%-28.0% during 1980-84. As a result, there is currently an almost equal frequency of cancers involving either the most proximal or distal 20-25cm of the large bowel, with each being the site for approximately one quarter of all colorectal carcinomas. Another one-fourth of tumors occur within the longest portion of the large bowel that consists of transverse and descending colon, whereas the remaining quarter are found in the sigmoid loop.

Our statistical data are comparable to and support the results of studies conducted in other states which have also shown a progressive left-to-right shift in the distribution of carcinomas within various anatomic segments of the colon.[8-12,15] Netscher and Larson[10] evaluated 204 colorectal cancers treated at the University of Louisville Medical Center during two five-year periods, 1957-61 and 1977-81. They found an 11% increase in right colon cancers, with a corresponding decrease in the frequency of tumors occurring in the left side of the colon. Maglinte, *et al.*,[15] analyzed colorectal cancer data on 2,298 patients treated at the Methodist Hospital of Indianapolis during the 1960s and 1970s. Carcinomas of the cecum and ascending colon increased by 7.8%, while sigmoid and rectal malignancies declined by 7.5% during this interval. A similar study was conducted at the Mount Sinai Hospital of New York City.[11] Comparison of data from 1966-67 and 1976-77 disclosed that the number of right colon cancers had increased from 19.4% to 28.6%, indicating a 9.2% gain in their incidence. The frequency of transverse colon tumors had also changed from 4.2% to 10.8%, accounting for an additional 6.6% increase in their rate of occurrence. In contrast, carcinomas involving the entire left colon beyond the splenic flexure had declined from 76.3% to 60.6%,

resulting in a 15.7% decrease in their incidence over a decade.

It should be noted that a similar pattern of proximal shift in colorectal polyp distribution has been observed by Bernstein, *et al.*[16] Their recent review of 967 polyps showed the following anatomic sites of occurrence: cecum and ascending colon (18%), transverse colon (16%), descending colon (18%), sigmoid and rectum (48%). However, both the size and number of the proximal colon polyps increased significantly with advanced age. In patients below age 50 the right colon contained 6.9% of the polyps, but the incidence increased to 29.3% beyond age 80. The opposite occurred in the distal colon. The rectum and sigmoid harbored 73.6% of polyps found in the younger group, as compared to 31.7% of the lesions detected among patients older than 80 years.[16]

Several factors have been implicated as the potential cause of the progressive left-to-right shift in the colorectal cancer distribution. For example, rigid proctoscopy and sigmoidoscopy have been widely used during the past three decades for the detection and removal of adenomatous polyps. The elimination of such premalignant lesions may have contributed to the reduced incidence of cancers in the distal colon.[17,18] At the same time, however, there has been an actual increase in the number and relative incidence of proximal colon cancers among the U.S. population.[1,2,8-12] This is in part due to the high consumption of animal fat in the American diet, a low-fiber content, and the carcinogenic effects of excreted bile upon the colonic mucosa.[3-5] Furthermore, recent experimental and clinical studies have shown a significantly-increased rate of carcinomas in the right side of the colon following cholecystectomy.[6,7] This operation has been performed on an estimated half-million Americans each year. Hence, it is possible that the enlarging population of post-cholecystectomy patients has led to the increasing frequency of proximal colon cancers during the past few decades.

Our documentation of the left-to-right shift in the anatomic distribution of colon carcinoma mandates a change in the current practice and diagnostic approach towards this malignancy. Guidelines published by the American Cancer Society in 1980 state that all persons over age 40 should have a digital rectal examination each year. Individuals beyond age 50 should also have a fecal test for occult blood annually, as well as a proctosigmoidoscopy every three to five years after two initial studies performed one year apart are negative.[19]

These recommendations were based on the assumption that more than 50% of colonic polyps and cancers occur within the most distal 25cm of the large bowel and could be detected by either digital examination or with a rigid sigmoidoscope.[19,20] However, our review of 887 cases of colorectal carcinoma diagnosed during a recent five-year period disclosed that only 27% of the tumors were located within the 20-25cm segment which encompasses the rectum and sigmoid. Furthermore, only the distal 16cm can be effectively visualized with a rigid proctosigmoidoscope, despite a theoretically obtainable 25cm depth of insertion.[21] It has been shown that the use of this instrument for evaluating the area 16-25cm above the anal verge leads to 27% false-negative studies.[20,22]

The modern 60cm-long flexible sigmoidoscope can substantially improve diagnostic yield. A multicenter evaluation of this fiberoptic device resulted in a six-fold increase in the detection rate of polyps and twice the number of diagnosed colorectal cancers when compared to the rigid sigmoidoscopy.[23] Nevertheless, approximately 50% of all adenomatous polyps and carcinomas of the large bowel occur proximal to the splenic flexure; these lesions will be beyond the reach of the 60cm sigmoidoscope.[15,16] The early detection and accurate diagnosis of colorectal tumors will depend upon techniques which permit visualization of the entire colon. For this purpose colonoscopy or barium enema examination is suitable as the initial diagnostic method, as well as for periodic screening of the high-risk group of patients.[18,24-28] These include individuals with chronic ulcerative colitis, familial polyposis and Gardner's syndrome, previous colorectal polyp or carcinoma, and those with family history of large bowel cancer.[15,19,26]

The unique advantage of colonoscopy is that direct visualization of the intestinal mucosa can be supplemented by biopsy of suspicious lesions and removal of pedunculated polyps. It is also 10%-12% more accurate than barium enema in terms of detection of polyps, particularly in patients with redundant sigmoid and diverticulosis.[15,26] However, the procedure is not error-free, and carries a 1%-2% rate of complications such as hemorrhage and perforation.[24,26,29]

Radiological colon studies by conventional barium enema or double-contrast technique offer a safe, simple and economical alternative. Such a diagnostic examination can be performed by virtually all practicing radiologists, and the relative cost is usually 10%-20% that of colonoscopy.[30] Johnson, *et al.*,[27] reviewed a total of 1,140 primary colorectal carcinomas diagnosed in 1,084 patients at the Mayo Clinic during 1976-1981. Both the single and double contrast barium enema examinations proved equally sensitive in detecting colon cancer, the error rates being 4.7% and 4.8%, respectively. In another recent investigation, De Roos, *et al.*,[28] examined each of 425 consecutive patients with both single and double-contrast enema done as a biphasic study during the same session. There was no significant difference in terms of cancer detection, but double-contrast barium enema proved far superior in the diagnosis of rectal and colonic polyps. Several other authors have also emphasized that double-contrast colon examination represents a more accurate radiological method for the diagnosis of colorectal lesions.[13-15,29] This technique would be more appropriate for screening and early detection of polyps and cancers of the large intestine, particularly among patients who are at high risk for this malignancy because of their advanced age, family history or other predisposing factors. In such cases the American Cancer Society recommends an

annual stool test for occult blood as well as digital and proctosigmoidoscopic examinations supplemented by double-contrast barium enema or colonoscopy.[9,12-19,31] The latter two procedures could be performed alternatively, perhaps at periodic two-to-three year intervals, to assure a complete visualization of the large intestine for early diagnosis of colorectal polyps and tumors.[15,16,24-30] Asymptomatic patients with positive hemoccult tests would also require a thorough evaluation of their colons because endoscopic examination of the rectosigmoid region alone is insufficient to exclude neoplastic disease. Recent studies have shown that the source of such occult hemorrhage is frequently a right-sided colonic lesion. Double-contrast barium enema represents the most cost-effective method for their detection.[31] ◀

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A list of references to "Colorectal Carcinomas" may be obtained by writing the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

EDITOR'S NOTE: Illustrative material for this article is available from the authors by writing them in care of the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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Of Obscure Origin

Recurrent Gastrointestinal Bleeding

By John V. Jurica, M.D., and Joseph E. Ross, M.D./Rockford

A 38-year-old woman presented six times over a seventeen-month period with recurrent gastrointestinal bleeding. Multiple upper and lower endoscopic examinations, radionuclide scans and contrast roentgenograms, including enteroclysis of the small bowel, were negative. Angiography ultimately revealed a vascular small bowel lesion. At surgery this proved to be a leiomyoma of the distal jejunum. Angiography should be considered early in the evaluation of recurrent gastrointestinal bleeding of obscure origin, even in the absence of active bleeding.

Recurrent gastrointestinal bleeding of obscure origin can be a challenging clinical problem. Small bowel lesions beyond the reach of the esophagogastroduodenoscope and colonoscope are often responsible. Complete evaluation of such bleeding may require small bowel x-rays, enteroclysis, radionuclide studies and angiography. Benign and malignant tumors of the small bowel and vascular anomalies must be considered. Described here is a patient with recurrent gastrointestinal bleeding secondary to a benign leiomyoma of the small intestine. Diagnostic modalities useful in the detection of small bowel pathology are discussed.

Case Report

This 38-year-old black woman presented with fatigue and melena. Physical exam at presentation was unremarkable except for pale sclera and nailbeds. She had no stigmata of familial polyposis syndromes or inflammatory bowel disease. She had a hemoglobin of 3.7mg/dl and was hospitalized. Work-up included flexible sigmoidoscopy, barium enema, upper GI x-ray with small bowel follow through, esophagogastroduodenoscopy (EGD) and a Technitium-99m (TC-99m)-tagged red blood cell (RBC) scan. All of these exams were negative. She received four units of blood during her hospitalization and was discharged with no further evidence of bleeding.

The patient was hospitalized five times over the next seventeen months with severe anemia secondary to recurrent gastrointestinal bleeding. She required a total of 19 units of blood during this time and underwent repeat colonoscopy twice, TC-99m RBC scan twice, EGD and an enteroclysis examination of the small bowel. None of these studies disclosed a source of bleeding.

During the most recent admission, a third TC-99m RBC scan suggested a bleeding source in the small bowel. A selective mesenteric angiogram showed a 7cm collection of blood vessels with early filling, capillary blush and early venous run-off, suggesting an arteriovenous malformation (AVM) or vascular neoplasm in the jejunum. There was no extravasation of dye.

The patient underwent an exploratory laparotomy which revealed a 6cm in diameter antemesenteric pedunculated tumor of the distal jejunum with large feeding vessels. This was removed with several centimeters of normal bowel on either side of the tumor. Pathologic findings indicated a 6cm polypoid mass extending from the serosal surface into the bowel lumen. It was firm and rubbery with hemorrhagic cystic degeneration in its center. On the mucosal surface of the bowel there was a 1.2cm nodule containing a central blood-filled punctum which extended into the tumor mass. Microscopically there was proliferation of smooth muscle cells, mild nuclear pleomorphism and mild mitotic activity, consistent with a benign leiomyoma.

The patient had an uneventful postoperative course and was discharged five days after surgery.

Since discharge she has had no recurrence of gastrointestinal bleeding.

Discussion

As illustrated here, gastrointestinal bleeding from a source not accessible to upper and lower endoscopy can be a very frustrating and costly problem. In patients with acute GI bleeding the cause will remain obscure in approximately 5%.[1] Multiple hospital admissions may be required before a definitive diagnosis can be made. These patients often receive many blood transfusions and are exposed to the accompanying risks. Leiomyomata, other neoplasms and AVMs of the small bowel and Meckel's diverticulum must be considered as causes of recurrent bleeding of obscure origin.[2,3]

Small bowel neoplasms comprise only 3%-6% of all gastrointestinal tumors.[4] However, when esophageal, gastric, duodenal and colonic sources of GI bleeding are excluded, leiomyomata and other neoplasms of the small bowel become much more likely. Leiomyomata comprise 22%-43% of benign small bowel tumors.[5,6] Forty to fifty percent of these tumors present with gastrointestinal bleeding.[6] They may also present with fatigue, weight loss, abdominal pain or obstructive symptoms. Patients with this condition as a cause of GI bleeding often have multiple hospital admissions. Perforation of these tumors is rare, but has been described.[6,7] These tumors can occasionally be diagnosed on small bowel contrast x-rays. Most can be detected by angiography, where they have a characteristic pattern, as described in the case report.[8]

This case represents a typical course for a patient with recurrent gastrointestinal bleeding from the small intestine. Evaluation of such patients usually entails routine small bowel x-rays, enteroclysis, radionuclide scans, angiography and, sometimes, exploratory laparotomy. Small bowel follow through x-rays may demonstrate changes consistent with inflammatory bowel disease, or may reveal intraluminal small bowel tumors if many spot films are done during the exam. Enteroclysis, a technique whereby barium is instilled directly into the small bowel by a nasoenteric tube, can reveal lesions missed on routine small bowel x-ray.[9] Either single or double contrast technique may be employed, the latter using air or a solution of methylcellulose as the second contrast medium.[10] Most enteroclysis exams last about 20 minutes if there are no abnormal findings, and slightly longer if an abnormality is detected.

Various scintigraphic techniques can be used to detect sources of GI bleeding in the small gut. Technitium-99m sulfur colloid (routinely used for liver spleen scans) can be used to detect acute GI bleeding.[11] Because the half-life of the tracer is only 2½ minutes, this method will only detect active bleeding at the time of the test. However, bleeding rates as low as 0.1ml/min. can be detected. Unfortunately, bleeding in the right or left upper quadrants of the abdomen may be obscured by hepatic or splenic uptake of this radiopharmaceutical.

TC-99m-tagged RBC imaging is more commonly used than sulfur colloid.[11] With this technique the patient's own red blood cells are tagged with the tracer and reinjected. This method has the advantage of being able to detect both acute and intermittent bleeding. After one injection of tagged RBCs, repeated imaging can be performed for 24 to 36 hours. However, there must be 500ml or more of blood extravasated within 24 hours to obtain a positive scan. Results can be misleading if there is rapid transit of bowel materials through the gut; tracer material detected in the large intestine may have been extravasated in the small intestine and then moved by peristasis to its distal location. In spite of these limitations this is a noninvasive test with estimated sensitivity and specificity rates of 90% and 95%, respectively. This study can often be used as a screening test to document active bleeding prior to performing angiography.

The TC-99m pertechnitate scan can also be used to identify a likely bleeding site.[11] This radionuclide accumulates in gastric mucosa, including that found in a Meckel's diverticulum. Though it does not confirm active bleeding, it can demonstrate a likely source of bleeding, especially in young patients.

It is generally accepted that angiography is most useful when it is performed at the time of active bleeding, in order that luminal extravasation might be demonstrated. In those with brisk GI hemorrhage the procedure can be therapeutic as well as diagnostic by the infusion of vasopressors. However, angiography should also be strongly considered in patients with chronic recurrent bleeding severe enough to require multiple transfusions.[3] Many vascular anomalies and certain types of tumors will be visualized on angiography even in the absence of active bleeding. The angiogram will provide a diagnosis in 43%-74% of patients with recurrent gastrointestional bleeding of obscure origin.[12,13] Patients with a normal angiogram are unlikely to require surgical exploration and do well with conservative medical therapy.[13]

Conclusion

Diagnosis of obscure recurrent gastrointestinal bleeding requires a systematic approach. Most cases are caused by vascular anomalies or tumors of the small bowel. Radiocontrast studies such as routine small bowel x-rays or enteroclysis are well tolerated and may give the diagnosis in some cases. Angiography must be strongly considered in these patients even in the absence of acute bleeding. Leiomyoma of the small intestine is one of the more common small bowel neoplasms which may cause recurrent gastrointestinal bleeding.

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A Case Report

Cancer of the Trachea

By Hee Jae Yoon, M.D., Jen-Hung Chao, M.D., and Edwin J. Liebner, M.D./Chicago

Primary cancer of the trachea is very rare. It has been estimated that one tracheal cancer is found in every 15,000 to 20,000 autopsies. There is a paucity of experience, both in the behavior of primary tracheal tumor and its response to modern surgical treatment and radiation therapy. Resection and reconstruction with the addition of postoperative radiation appears to offer palliation and the best chance of cure for squamous cell carcinoma and adenoid cystic carcinoma of the trachea. Primary radiation therapy should be considered as a curative modality. Long term survival is frequently achievable with surgery, radiation or a combination of these two modalities.

A 50-year-old black female, who had been diabetic, was admitted to our institution with acute onset of shortness of breath, wheezing and cough of several hours duration. She had suffered a stroke one year prior with subsequent right hemiplegia and dysarthria. The patient was coughing out whitish sputum and denied hemoptysis or chest pain. Throughout the lung, bibasilar rale, rhonchi and wheezing were auscultated. Heart examination was unremarkable except for questionable systolic murmur at the apex. The patient was managed with aminophylline, oxygen and respiratory therapy.

During the first week of hospitalization, the patient had several acute episodes of shortness of breath. Chest x-ray revealed a round density adjacent to the upper mediastinum on the right side. Lung scan and esophagogram were normal. A hard, right pretracheal node was palpated behind the right sternocleidomastoid muscle on repeated careful physical examination. Thyroid function test was within the normal limit. Bronchoscopy revealed a whitish mass at the level of the carina, impinging from the posterior right lateral wall of the trachea. Tomogram of the trachea confirmed a large mass almost completely obliterating it from the right side. (Figure 1) Bronchoscopic biopsy from this endotracheal mass was reported as connective tissue lined by respiratory epithelium and squamous metaplasia and marked dysplasia. Isolated anaplastic malignant cells were seen. Incisional biopsy of the right pretracheal node was reported as poorly-differentiated squamous cell carcinoma (Figure 2), which was similar in appearance to those of the previous tracheal biopsy.



Figure 1
Tomogram of the trachea showing a large intrinsic mass which is almost completely obliterating the trachea from the right.

Radiation therapy was given to the mediastinum covering the primary site and the pretracheal nodal area with 32MeV betatron. Field size was 7×7cm. Treatment consisted of 200cGy per day at the midplane, for a total dose of 6,000cGy in 30 fractions for 43 days, with anterior-posterior opposing fields. Patient responded to the

radiation therapy very well; aminophylline was discontinued after the twelfth treatment (2,400cGy) and oxygen was discontinued after the seventeenth treatment (3,400cGy). The patient tolerated the treatment well and has been followed regularly with periodic chest x-rays. Tracheotomogram taken nine months after completion of radiation therapy demonstrated complete regression of the tumor. (Figure 3) No symptomatic and radiographic findings suggestive of recurrence or metastasis have been noticed to this time, fourteen years following treatment.

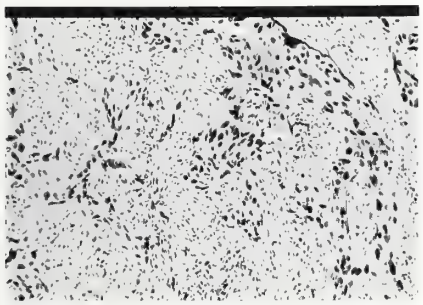


Figure 2
Cord of squamous cell carcinoma with moderately pleomorphic nuclei, grown in an irregular infiltrative pattern, H&E (×100).



Figure 3
Normal tracheotomogram taken nine months after completion of radiation therapy.

Table 1
Histologic Distribution of Primary Tracheal Cancer

	Xu	Hajdu	Houston	Rostom	Total	%
Squamous	3	30	24	28	85	57.0
Adenoid Cystic	3	7	19	3	32	21.5
Adeno	—	4	1	4	9	6.0
Others	4	—	9	10	23	15.4
Total	10	41	53	45	149	

Discussion

Primary cancer of the trachea is not common. As reported in England,[1] 2.6 new cases per million population per year are diagnosed. Among the 149 primary tracheal cancer cases reported by Rostom, *et al.*,[1] Houston, *et al.*,[2] Hajdu, *et al.*,[3] and Xu, *et al.*,[4] squamous cell is the most common histologic type, with adenoid cystic and adenocarcinoma following. (Table 1) Peak incidence of squamous cell carcinoma is between 50 and 60 years of age, while the incidence of adenoid cystic carcinoma is approximately a decade earlier.[2] Common symptoms are dyspnea, cough, hemoptysis, stridor and wheezing, hoarseness and dysphagia. (Table 2) Average duration of these symptoms is two to 10 months. Characteristically, dyspnea due to tracheal tumor is frequently paroxysmal and occurs most often at night when the patient is recumbent.

Chest x-ray combined with tracheal tomography and CT scan are important radiologic investigations, not only to show the tumor site, but also to obtain information about the size, particularly the lower extent, adequacy of airway and presence of extratracheal extension. Barium swallow can demonstrate advanced cases of esophageal tumor infiltrating the posterior wall of the trachea. Bronchoscopy is essential in investigating tracheal tumor, since most patients have normal chest x-ray findings.

In most reports by surgeons, tracheal resection has been used as the primary method of treatment. It has been claimed that as much as 6cm of trachea can be excised and closed, primarily without prosthesis, in tracheobronchial structures.[5,6] Resection should be the primary method of treatment for radioresistant lesions—chondrosarcoma, adenocarcinoma and perhaps, adenoid cystic carcinoma.

Primary radiation therapy should

Table 2
Common Symptoms of Primary Tracheal Cancer

	Grillo	Hajdu	Houston	Rostom	Total	%
Dyspnea	44	8	39	36	127	24.3
Cough	22	14	45	25	106	20.3
Hemoptysis	28	11	35	25	99	18.9
Stridor/Wheezing	28	—	32	12	72	13.8
Hoarseness	13	11	7	11	42	8.0
Dysphagia	13	5	12*	8**	38	7.3
Weight Loss	—	8	10	6	24	4.6
Pneumonia	10	—	—	—	10	1.9
Chest pain	—	5	—	—	5	1.0
Total	158	62	180	123	523	

*Including discomfort in the chest
**Including retrosternal fullness or sensation of foreign body in the throat.

Table 3
Survival Rate of Primary Tracheal Cancer

	0-2 Yr	2-5 Yr	5-10 Yr	More than 10 yr	Total
Grillo	12(42.8%)	7(25.0%)	6(21.4%)	3(10.7%)	28
Hajdu	32(78.0%)	1(2.4%)	4(9.8%)	4(9.8%)	41
Houston	21(48.8%)	5(11.6%)	9(20.9%)	8(18.6%)	43
Total	65(58.0%)	13(11.6%)	19(17.0%)	15(13.4%)	112

be considered as a choice of treatment in such cases as squamous cell type, especially for the patient with a disease limited to the trachea. In a series reported by Rostom and Morgan,[1] 39 patients had been treated with Co^{60} gamma ray, 2MeV or 6MeV x-ray, usually in supine cast with full extension of neck. Two anterior-wedged oblique fields were usually used. The dose to the spinal cord was usually 10%-40% of that given to the target volume.

Among 24 patients with squamous cell carcinoma who had received radical doses (6,000-7,000 cGy in 6-7 weeks), 16 patients (66.7%) had complete regression of local disease. At least nine out of 39 patients (23.1%) had survived for more than five years in their series.

Long term survival is not rare in primary tracheal cancer. (Table 3) Among the 112 patients collected from the series reported by Grillo, Hajdu and Houston, 47 patients (42.0%) had survived for more than two years and 34 patients (30.4%) have survived for more than five years.

Acknowledgement

The authors would like to thank Drs. James Lo, Christopher Fung and Victor Fernandez, department of pathology, Mercy Hospital, Chicago, Illinois for their help and advice.

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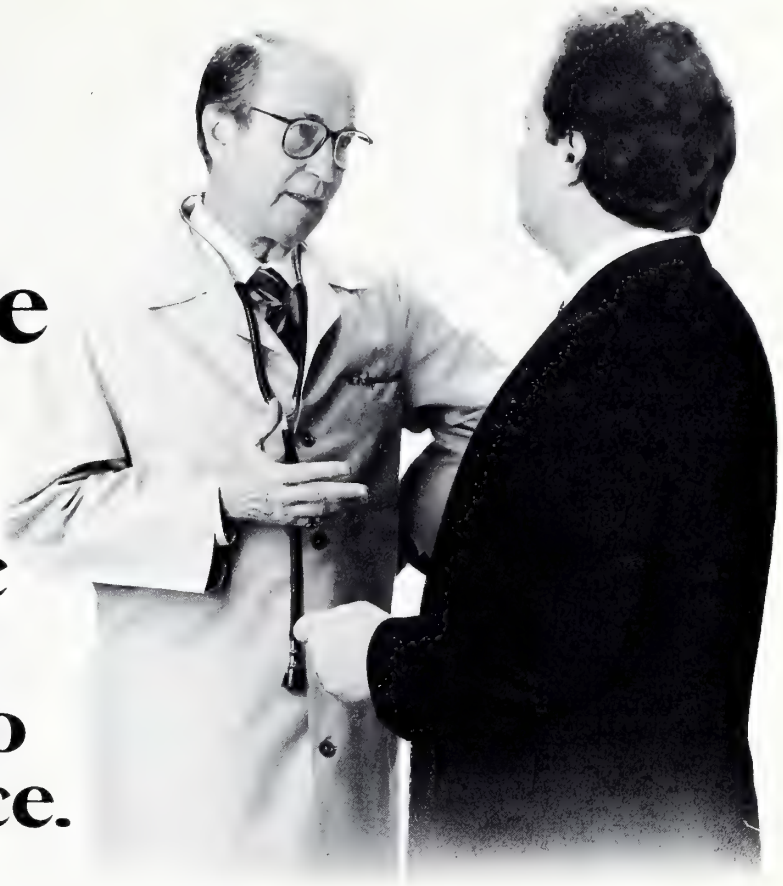
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Dr. Charles Chandler of Chandlerville

By Emmet F. Pearson, M.D./Springfield

Dr. Charles Chandler of Chandlerville was born in Woodstock, Connecticut in 1806, one of a large clan of Chandlers prominent in New England. Several Connecticut towns were named for towns in Hertsforshire, England, from which the American Chandlers had come. Most Chandlers were said to have remained Royalists during the American Revolution, but apparently they had been able to retain their privileged positions after the war. Some of the choice genes of this bright and industrious clan may have entered Charles' chromosomes.

Charles' father, John, inherited land from his father, enabling him to live wholesomely, if frugally. Charles was encouraged by his family in his desire for higher education. He obtained his M.D. degree from the Medical College of Castleton, Vermont in 1824. After graduation, Charles married Mary, his sweetheart from a neighborhood family in Woodstock. He entered private practice in Scituate, Rhode Island the same year, and built a substantial home shortly afterwards. A daughter, Mary Jane, was born in 1830.

On a cold winter day in 1831, a group of neighbors met in Charles' home. His brother Marcus read incredible reports from beautiful, fertile and virgin land in Illinois. It seems that the Indians had recently departed and the land was available as "free soil." Charles rose and said, "I for one have made up my mind to sell my possessions, dispose of my practice and plan to leave for Illinois, come spring—that is, if my wife will agree to go with me." Mary later agreed to go if he would build her a house like the one they would be leaving.



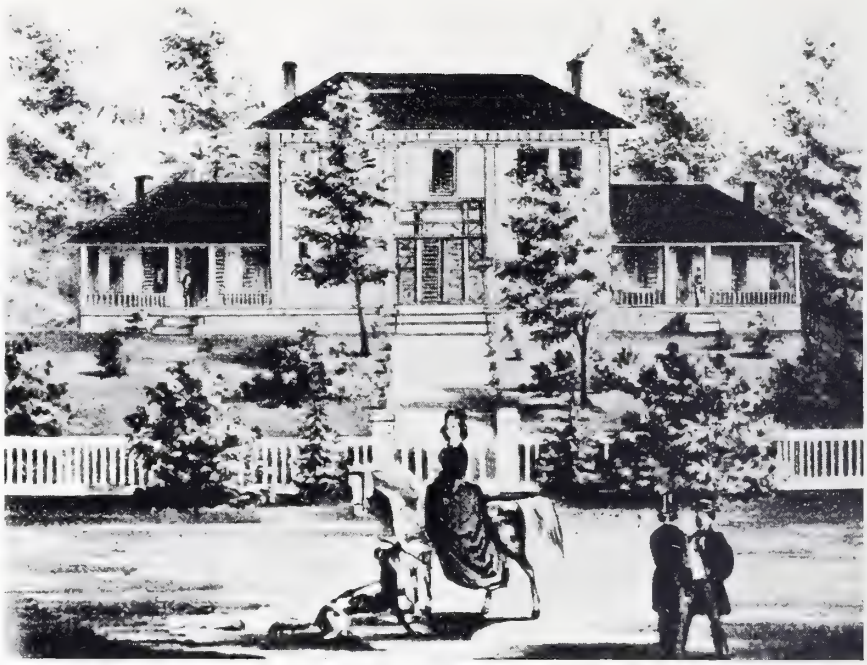
Photo of Dr. Charles Chandler, circa 1850. Reprinted with permission of the Illinois State Historical Library, Springfield, Illinois.

With their infant daughter, the Chandlers proceeded westward down the Ohio River, around the southernmost tip of Illinois, and then up the Mississippi River to St. Louis. The steamboat was just coming into use at that time. Reports in St. Louis indicated that an Indian chief named Black Hawk was forcing his way to the hunting grounds of the Sac and Fox tribes in upper Illinois. With this disconcerting news, some of the New Englanders turned back, but Charles and his family chose to proceed up the Illinois River to Fort Clark (near what is today the city of Peoria). When the Chandlers arrived at what is now Beardstown, then the site of a prominent Indian mound which was first described by Marquette and Joliet, they saw soldiers gathering to respond to Governor Reynolds' call for volunteers to counter the Indian threat. Settler Thomas Beard and others advised the Chandler group not to proceed upstream. Instead, Beard took Chandler on horseback easterly to a pleasant place on Panther Creek. Chandler decided that this site would be their home, staked his

claim for 160 acres and later built a cabin. There is now a cenotaph standing on the bluff where Charles made his decision to stake his life on this claim.

Dr. Chandler had not finished his cabin before calls began for him to attend the sick and injured. His practice extended in a twenty-five-mile radius which included several counties. Dr. F.S. Snyder of nearby Virginia, Illinois, a prominent colleague and descendent of the earliest French settlers in Illinois, could not comprehend how Chandler was motivated to leave his comfortable practice in prosperous Rhode Island for the rigorous life of this relatively unexplored territory. The new settlement was the furthest north of any pioneer group in Illinois except Galena.

Charles Chandler played a prominent role in creating the intellectual and spiritual position held by pioneer doctors in central Illinois. He had come to the wilderness with a strong determination to promote the medical humanities and a quality of life. He encouraged higher education and witnessed the American Civil War and the Industrial Revolution.



Artist's view of the Chandler homestead, Chandlerville, Illinois. Reprinted with permission of the Illinois State Historical Library, Springfield, Illinois.

First Specific Drug Therapy in Illinois

Chandler soon encountered ague, or malaria. in Illinois. Fortunately, he had brought with him his "Chandler pills," quinine tablets, from Rhode Island. As a result, he is given credit for introducing this drug—the first specific medicine for any disease—into Illinois. Chandlers' daybook shows that he regularly dispensed quinine, and on one occasion even sent some to his old friend Thomas Beard in Beardstown. Dr. Chandler, however, apparently did not like taking "Chandler pills" and would tolerate the chills and shakes, perhaps to conserve the quinine for his worst cases.

Charles rose and said, "I for one have made up my mind to sell my possesions, dispose of my practice and plan to leave for Illinois, come spring—that is, if my wife will agree to go with me." Mary later agreed to go if he would build her a house like the one they would be leaving.

Chandler is said to have introduced quinine to Dr. Arthur Prince at Illinois College Medical School in Jacksonville where he also treated cholera, which had reached epidemic proportions, and was causing sudden deaths.

Chandler did not practice the technique of bleeding so common among his contemporaries, especially those in the East. He evidently did not believe in excess purging with calomel or induced vomiting by tarrar emetic. Chandler practiced allopathic medicine and used such medicaments as boneset tea, aloe and blue mass. His obstetrical knowledge was highly respected.

Patients would say of Dr. Chandler, "He doesn't bleed you till you are weak and faint and he doesn't make you puke until your innards are wretched apart." One settler liked to tell the story that the doctor saved his daughter from fever by calling on her every day. Another settler who lived across Salt Creek said that the doctor swam with his horse across the creek to see his son, who was choking with putrid fever, or diphtheria. We do not know if Dr. Chandler used intubation in such cases, but that apparatus could have been available.

The previous winter of 1831 had been the year of the great snow in Illinois, and the hardships of man and beast were still in everyone's thoughts. The summer of 1832 was hot and there were swarms of flies and mosquitos. Sick children and epidemics prevailed. Dr. Oren Long was practicing in Beardstown, a few miles west of Chandlerville, and Dr. John Allen was to the east in New Salem on the Sangamon River. Dr. Ero Chandler (unrelated to Charles) was in Jacksonville, twenty-five miles to the south. There was no school within twenty miles of Panther Creek and no church. After reports from Dr. Chandler to his former home, five of his brothers and sisters and their children came from Connecticut and joined others in Panther Creek. Marcus Chandler, Charles' brother, became one of Charles' partners in various undertakings. In 1836, as Charles had promised his wife, the Chandlers built and moved into a new home similar to the one they had left in Connecticut.

On a winter day in 1836, there had been rain and some snow. Dr. Chandler was hurrying home from a house call when a change in the weather came up suddenly. Chickens and game were frozen to the fences and much wildlife perished. Dr. Chandler's horse fell from exhaustion and died near his home. The doctor was thrown to the ground and his clothing was frozen. Fortunately, some people heard his distress calls and dragged him to the safety of his home.

A Community Takes Shape

Charles undertook many new projects, including building a blacksmith shop and a store, with his brother Marcus. They imported necessities and shipped grain and other commodities to St. Louis and down the Mississippi River. Charles was interested in churches, parks, schools, politics, and railroads and donated money to them, but he was modest and had an aversion to public life. He did not take leadership in these enterprises, although he was a founder of the Republican Party at a meeting in Decatur.

Mary Chandler gave birth to a son, named Charles, and then two more daughters, Emily and Louise, before dying after a fifth pregnancy in 1840. After Mary's death, Charles courted Clarissa Child from Woodstock, Connecticut, who had come to visit her sister in Panther Creek. Evidently, Dr. Chandler pursued her back to Connecticut, where they were married and brought Clarissa back to Illinois. Two sons, Linus and John, were born to Clarissa.

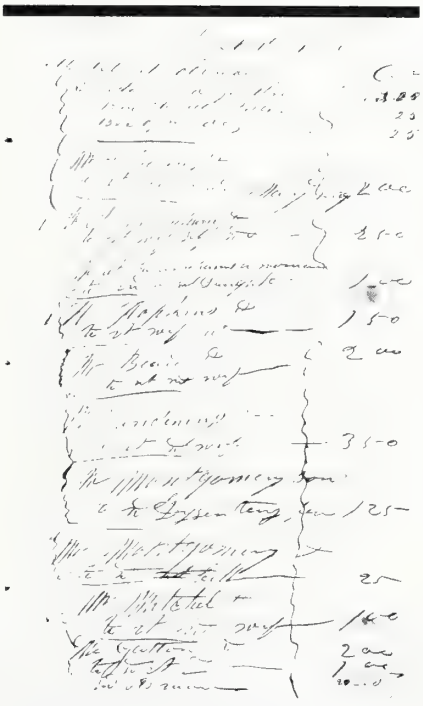
In 1838 Chandler's daybook showed a monthly average credit of about $1,000. He did a great deal of charity work. About $40,000 in uncollected accounts was discovered on his books at the time of his death in 1879.

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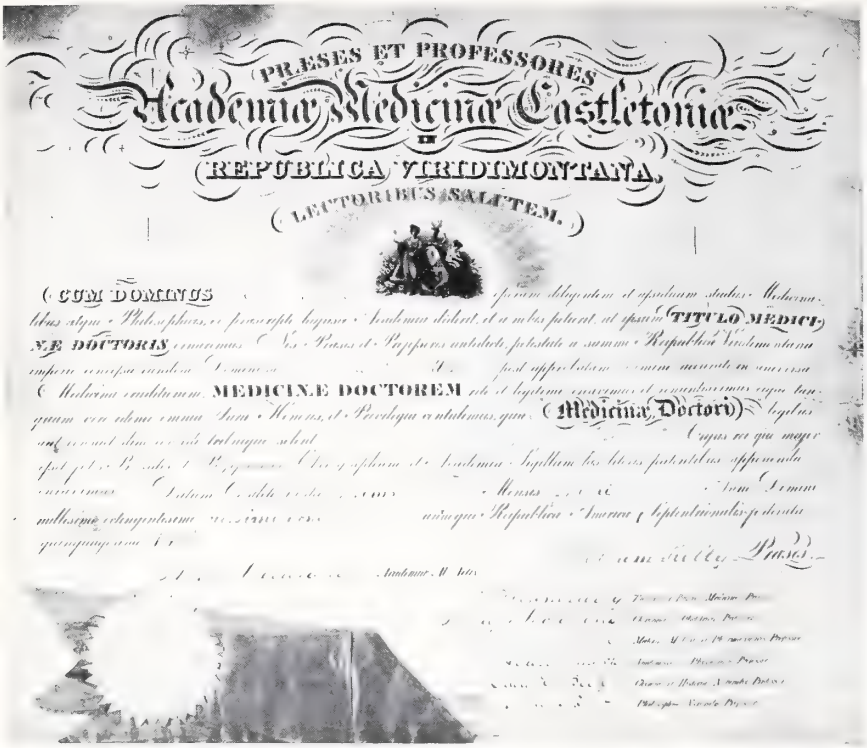
In 1842 a new medical school was founded at Illinois College by David Prince, a professor of anatomy and surgery. The fee was $60.00 a year, and $5.00 was charged for tickets for private anatomy lessons. Dr. Chandler served on the board of censors, which judged the students who could qualify to be recommended for the degree of doctor of medicine. Some students "rode with" Dr. Chandler and lived in his home. Dr. Prince met his future wife and Chandler's niece, New Yorker Lucy Manning, in Chandler's home.

Charles Chandler's daughters Emily and Louise were sent to school at Monticello in 1850. Monticello Seminary, the first lady's seminary in Illinois at Godfrey near Alton, was built in 1837 by Captain Benjamin Godfrey. To travel to Godfrey it was necessary for the girls to go down the Illinois River in a boat operated by their brother, Charles. There are extant letters sent by Chandler to his daughters at Monticello in which he expressed his philosophy and pride in education.

Dr. Charles Lippincott, a local physician who started medical school at Illinois College and graduated from Pope Medical College in St. Louis, came to Panther Creek to practice with Dr. Chandler. Lippincott was the son of a famous minister who had been a founder of Illinois College. Emily Chandler came home from Monticello Seminary, met Lippincott and married him. Lippincott joined a group of people from Panther Creek who



A page from the daybook of Dr. Charles Chandler, 1838. Reprinted with permission of Sangamon State University, Springfield, Illinois.


PRÆSES ET PROFESSORES
Academiæ Medicinæ Castletonia
REPUBLICA VIRIDIMONTANA
LECTORIBUS SALUTEM.
CUM DOMINUS
TITULO MEDICI-
NÆ DOCTORIS
MEDICINÆ DOCTOREM
(Medicinæ Doctori)

Medical diploma of Dr. Charles Chandler from Castleton, Vermont, 1826. Reprinted with permission of Sangamon State University, Springfield, Illinois.

were travelling to the West Coast for the Gold Rush, leaving Emily at home to teach school. Lippincott later was elected a state senator in the new state of California, fought a duel there and killed his opponent, and then returned to Illinois.

Lippincott persuaded politicians, including Stephen A. Douglas, to change the name of the town Panther Creek to Chandlerville in honor of his preceptor and the town founder. A post office was established and Chandler was made postmaster.

An Important Friendship

According to Abraham Lincoln's law partner, Billy Herndon, Chandler met the future president during a hurried trip to Springfield to make a claim for a parcel of land. Another man was trying to make the same trip for the same purpose. A man on horseback, seeing that Chandler's horse was weak from exhaustion, offered to loan him his horse to make the trip to Springfield. As a result of this kindness, Chandler did indeed get there first, and acquired the land. The man who had offered his horse was Abraham Lincoln.

Later, when Chandler wanted to have his town and land surveyed, he sent for the young surveyor from New Salem. Lincoln came to Chandler's aid, did the survey and remained for some time as a guest. Lincoln visited Chandler on several occasions and it is probable that Chandler gave him books and encouraged him to enter politics.

Dr. Chandler was always a strong supporter of Lincoln and helped form the Republican party when the Whig party broke up. Lincoln spent several nights in the Chandler home while campaigning for United States senator. Dr. Chandler and his son-in-law, Dr. Lippincott, could never agree on Stephen A. Douglas or Abraham Lincoln as candidates.

Dr. Chandler's life-long friend, Henry Chandler Bowing, had been asked to suggest a speaker for a Cooper Union address in February, 1860. Apparently on Dr. Chandler's recommendation, Abraham Lincoln was invited to speak on that occasion, which led to his national emergence as a presidential candidate. Chandler and Lincoln became life-long friends. Chandler attended the inaugural ceremony at President Lincoln's invitation and remained as his guest in the White House.

The names of several members of the Yale Band of Intellectuals who came to Jacksonville's Illinois College are shown in the dedication record book of a new Presbyterian church that was built by Charles Chandler in Chandlerville. The preacher at Chandler's church was

EDITOR'S NOTE: The story of Charles Ellet Lippincott was previously published in *IMJ* (Pearson, E.F.: "A Country Doctor of Adventuresome Spirit," Vol. 170, No. 2, 1986). Dr. Lippincott was a remarkably adventurous and ambitious man of the Civil War era. He received most of his higher education at Illinois College in Jacksonville and at the Illinois College School of Medicine. Dr. Lippincott married Emily Chandler on Christmas Day of 1851. After a few years of country practice, he joined the gold seekers in California, where he eventually became a prominent politician and state senator. After an infamous duel, Lippincott left California and became involved in the Civil War, where his heroism earned him the rank of brigadier general. In 1858 the Republican party nominated and elected him state auditor of Illinois. His last position was as the governor of a home for honorably discharged soldiers, established in Quincy in 1885 by the Illinois State legislature.

Jonathan B. Turner, who first advocated that the federal government grant land and money for universities such as the University of Illinois. Among the preachers who also offered spiritual instruction in Chandlerville was the famous Methodist, Peter Cartwright.

As roads improved Chandler began using a horse and sulky to make his rounds. One day in 1870 Chandler fell asleep while driving. His horse became frightened and threw him out of the sulky, causing some internal injuries. Pneumonia set in and thereafter Chandler's health was not good.

The problems between the states over the issue of slavery intensified. Chandler, although not a strong advocate of quick abolition of slavery, was philosophically against forced servitude. He felt that the dangers of rapid change would bring on more evil than a gradual evolution, which eventually could bring about the end of slavery.

As war came on, several members of the Chandler family, including Charles Lippincott, volunteered and were enlisted into the service. Chandler's son Harrison was injured and contracted typhus fever. Dr. Chandler brought him back to Illinois to recover and he soon returned to duty. Lippincott was involved in many encounters and rapidly rose in rank to brigadier general.

Chandler prepared his sons for higher education. Charles, the oldest son, prepared for a medical career by entering medical school in St. Louis. The two younger sons, John and Linus, were sent to Phillips Academy and to Harvard University. Linus completed law school and practiced in Chicago before the Great Fire. All sons married daughters of prominent families. Clarissa, Chandler's second wife, died in 1875.

On July 2, 1878, Dr. Chandler and his family celebrated his seventy-second birthday. Chandler's seven sons and daughters with their spouses and a total of sixteen grandchildren attended his party. All of his children were enjoying prosperity. Charles was seated in an armchair under a great tree and his grandchildren sang a song written in his honor. General Lippincott made a presentation and said that all felt "that no activity and business, no crowding care, no incidence and no busy full life was ever the thought of your family lost for a moment of your affection, your sympathy or your care. And not least precious of all the crowns of this anniversary of your life should be to you the knowledge that you have won and now hold not only the highest respect in pride to all your children, but their deep affection and tenderest love."

On April 17, 1879 Charles Chandler died, probably from heart failure. His words rang true: "We all ought to do some good in this world so when we come to die, that we may say that the world is no worse for us having lived in it. We can be of some use not only to ourselves but to others. We can be, if we choose, good example for others."

Charles Chandler's funeral was conducted by a good friend of many years, Reverend Albert Hale, who also preached the funeral sermon of Chandler's friend, President Abraham Lincoln. At the funeral, Dr. Hale said Dr. Chandler was an "epic character of a man. There's no purity of mind or character that can excel that of his manly heart. There's no kindness even of mother, sister or wife that can surpass the tenderness which dwelled in his nature. There's no courage higher or truer than that which always made him ready to devote himself to what he felt to be the right. Furthermore, as a man, one of the best, truest, noblest, let the men in Cass County mourn him, and above all, imitate him." ◀

"We all ought to do some good in this world so when we come to die, that we may say that the world is no worse for us having lived in it. We can be of some use not only to ourselves but to others. We can be, if we choose, good example for others."

Acknowledgment

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A complete bibliography for "Dr. Charles Chandler of Chandlerville" may be obtained by writing the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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Adolescent Sexuality

By Joanne Woiteshek (Mrs. Dwight), ISMSA Adolescent Sexuality Chairman

The issue of adolescent sexuality can be divided into two problem areas: (1) the emotional and physical growth and development of the adolescent, and (2) the societal issues of sexuality facing us in the twentieth century.

Many believe the sexual revolution of the 1970s is the cause of the problems in the 80s. Others believe the television and movie industries are to blame because of the amount of sexual viewing one may see in their own homes. Others place blame on magazines which publish vivid sexual experiences. As I research this subject, I'm convinced the media is not the only source of the problem. As more monies were put into the media, more monies were also used to educate people on the prevention of teen pregnancy, sexually transmitted diseases, and birth control methods. Teens continue to get pregnant in 1987 as they did in 1967. However, we now discuss it more openly.

The key to the problem is looking at an adolescent's emotional growth and development and her or his ability to problem solve. We all love to circle around problems (*i.e.*, teen pregnancy and adolescent suicide) instead of looking for means to develop a healthy adolescent. As parents and health care providers, we are missing the boat.

Last week, two nurses who work with pregnant teens reaffirmed my belief that teens become pregnant because of low self-esteem and an inability to problem solve. These skills should be learned as a preschooler, according to Eric Erikson, the noted psychologist, and are reinforced throughout each stage of growth and development. According to Erikson, the adolescent is working on identity vs. identity diffusion and independence. These developmental stages make parenting an adolescent a difficult balance, especially since we as a society don't spend much time or money developing parenting skills. The majority of parents today follow the examples of their parents. The adolescent needs the opportunity to make decisions, and parents need to accept the adolescent's decision, even though it may be a different choice than they would make.

When discussing the teen pregnancy problem with my 15-year-old daughter, I asked her why girls become pregnant when there was so much information out on prevention. She told me that kids cannot problem solve and they want to be accepted by their peers. I asked if they were concerned about AIDS—she laughed and said, "Mom, they think it will never happen to them, if they even know what AIDS is." This is a typical adolescent response. Adolescents are not future oriented, they are into the present and want immediate gratification. These traits may drive parents to lock their teenagers in their rooms. This may be an easy solution for the parent, but is not the way to develop a young adult.

So, what solutions do I have to offer? There are some wonderful educational experiences available for parents and kids. Parents should be aware of hospital programs offering parenting skill classes. Two books which I believe every adolescent and parent should read are Safe Sex in a Dangerous World by Arthur Ulene and Deep Blue Funk by Daniel B. Frank.

Parents need to begin working on problem solving and decision making with their children during the preschool stage. Make the choices suitable. "Where do you want to have lunch? (a) McDonald's or (b) Burger King?" But make sure to offer choices you can live with.

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Otitis media due to *S pneumoniae, Haemophilus influenzae,* staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis,* and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Reversible interstitial nephritis has been reported rarely. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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Exchange Insights

November 1987

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

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The Potential for AIDS-Related Malpractice

Five years ago an AIDS-related lawsuit would have been unheard of; even a couple of years ago, it would have been rare. Today, in contrast, a large variety of legal actions relating to AIDS have either already been brought or can be expected.

One can also assume that claims against physicians, hospitals, blood dispensers and pharmaceutical companies will expand as part of the growth of AIDS-related litigation. The possibilities are endless. Would it be reasonable for a patient, upon admission to a hospital for example, to demand he or she not be treated by gay or AIDS-affected medical personnel (and demand hospital certification)? Is it acceptable for medical personnel to refuse to care for patients with AIDS? In private hospitals? In public or governmental hospitals?

Seems outlandish. Think again. Witness the hospital nurse who nervously stuck herself with a needle after she learned from the patient she had just injected that he was suffering from AIDS. The nurse sued the admitting doctor who ordered the injection for not disclosing that the patient suffered from the potentially contagious disease.

The major issues facing the medical profession are likely to involve misdiagnosis of the disease, confidentiality and reporting, medical records maintenance, consent, and matters involving blood banking and transfusions. Let's take a closer look.

Diagnostic Problems. There is no simple and reliable test for AIDS. The ELISA (enzyme-linked immunosorbent assay), which is an effective blood screening test for the AIDS virus, is not a diagnostic test. It merely detects the presence of antibodies, indicating that an individual has been exposed to the Human Immunodeficiency Virus (HIV) believed to cause the disease. Although the low incidence of false negatives renders the ELISA test useful to screen blood, it often registers positive results when no antibodies are present, which impairs diagnostic reliability.

At the present time, the generally accepted method to diagnose the presence of AIDS antibodies is to conduct two successive ELISA tests. When both tests are positive, a Western Blot test is used to confirm the presence of antibodies: the Western Blot test identifies antibodies to proteins of a specific molecular weight. While the Western Blot test is more reliable than the ELISA test, so that it is less likely to register a false positive result, it is not a test for the HIV virus. One way of confirming an AIDS diagnosis is to follow the series of antibody tests with a T-cell test. The T-cell test measures the ratio of a person's two types of T-cell lymphocytes, which provide cell-mediated immunity and are effective against intracellular bacteria, viruses, and fungi. The combination of two successive positive ELISA tests and a Western Blot test, along with low T-cell levels, indicates that the HIV virus is present and is destroying the immune system mechanism.

An alternative method for diagnosing AIDS is to look for the presence of characteristic opportunistic or underlying diseases that indicate reduced T-cell levels. AIDS victims are susceptible to contracting certain diseases and opportunistic disorders caused by organisms commonly found in the environment but which are not harmful to a person whose immune system is functioning properly. Early symptoms include enlarged lymph nodes or swollen glands in the neck, groin and armpits, fatigue, loss of appetite, fever, night sweats, diarrhea, weight loss, persistent coughs, and various skin lesions. Fifty-two percent of AIDS patients develop a pneumonia caused by the protozoan *Pneumocystis carinii*, and approximately 37 percent develop a skin cancer Kaposi's sarcoma, or one of many other opportunistic infections such as cytomegalovirus, toxoplasma, or herpes simplex.

Although there is no known cure for AIDS, medical researchers agree that an aggressive clinical approach should be taken against recurrent, severe and multiple opportunistic diseases. In addition, there are several possible treatments for patients with pre-AIDS, or AIDS related complex (ARC). For example, the infection in its early stages may be susceptible either to treatment with antibodies directed against the envelope components of HIV or to antiviral chemotherapy. Early diagnosis would also enable victims to pursue measures aimed at decreasing the effects of the disease, such as special hygiene to reduce the chance of contracting opportunistic infections.

Misdiagnosis Liability. A medical malpractice claim could be based on one of several theories: failure to diagnose AIDS; erroneous diagnosis; failure to inform the patient of the diagnosis; or failure to provide proper counseling related to an antibody test.

Who might sue a physician? Potential plaintiffs would not only include the person who was misdiagnosed, but could extend as well to an infant born with AIDS whose parents were misdiagnosed, and to other persons who contracted AIDS from a victim who was misdiagnosed.

A misdiagnosis could result in delayed treatment, wrong treatment, aggravation and acceleration of the disease, and emotional distress. Liability could also be predicated on a misdiagnosis that a person suffers from the disease when in fact he does not. A mistaken positive diagnosis could result in therapy, loss of income and emotional damages.

Duty to Inform. The failure to inform a patient that he has AIDS can cause the same harm as would a misdiagnosis. Also, there is malpractice risk if a doctor fails to inform a patient of the meaning of test results, for example, from blood donor screening or insurance coverage examinations. A doctor's duty to inform the patient of positive test results under circumstances such as the above, however, is not clear. It is uncertain whether a physician-patient relationship exists where ELISA was administered as a screening device, not for diagnostic purposes. Assuming a duty to inform exists, the patient should know that, statistically, ELISA will result in a certain number of false positive and false negative results.

The duty to inform also precedes testing. AIDS testing should proceed only upon the informed consent of the patient, which means that the possible meanings of possible test results should be explained in advance, as well as whether testing will lead to the patient's name being placed on a Donor Deferral Registry (in California) or something similar. One commentator has suggested the following guidelines for explaining how test results should be interpreted.

Positive Test Result: A doctor should warn the patient that based on present knowledge a positive test result probably means: (1) that one has been exposed to the HIV virus, and consequently that one has been infected at some time and may transmit the virus or come down with AIDS, or a related disease, at some unknown time in the future; or (2) that one has never been exposed to the virus since there is a possibility of a false positive test result.

Negative Test Result: The doctor should counsel that either: (1) one was never infected and is in no danger of either coming down with AIDS or of passing the virus on to other people; or (2) one is infected with the HIV virus which is in an incubation period and that one may be able to pass the virus on to other people and may later develop AIDS; or (3) one is among the number of persons with AIDS who has had a false negative test result.

Providing proper information to a pregnant woman is a troublesome area. Based on available evidence, it is believed that there is a high rate of risk of perinatal transmission of AIDS. Women who are in high risk groups (or where there is evidence of the possibility of the disease) should probably be informed of the possibility of an antibody test, the meaning of a positive test result, and the possible damage to a child born to an infected mother.

Medical Record-Keeping. A medical record-keeping problem permeates AIDS health care. A delicate balance between any state requirements regarding confidentiality of patient medical information and requirements for reporting certain diseases may be required.

Blood Transfusions. A host of legal questions are presented by the possibility of AIDS transmission through blood transfusions. We will make here only a few points on this topic. Since March 1985, the ELISA test allows screening of blood donors. However, since there is some risk of false negative results due to the extended incubation period for the virus, a physician administering blood should inform the prospective recipient of the risk of infection from these products. By so informing prospective recipients, the doctor should be shielded from liability, unless he negligently performs the screening test.

Hospitals should establish procedures to insure as best as possible that blood it receives has been tested. The American Red Cross and other community blood centers notify all hospitals of donors who have tested positively, with disclosure to recipients to follow. Lawsuits are bound to follow, stemming not only from the possibility that the disease has been transmitted, but from the disclosure itself (suits from donors). The manner in which the disclosure is made to the blood recipients will also require special care, given the follow-up health care which may be necessary.

A complete bibliography for this article may be obtained by writing the Illinois State Medical Inter-Insurance Exchange, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Electrical muscle stimulation may exacerbate the symptoms of myasthenia gravis. The authors present a case of a 31-year-old female patient controlled on pyridostigmine 60mg qid. for myasthenia gravis. She had been involved in an auto accident and had been treated with short-wave diathermy, high voltage electrical stimulation and spinal manipulation for neck and low back syndrome. After six weeks she saw a neurologist because of fatigue, weakness, diplopia and cervical and occipital pain with disrupted sleep. The myasthenia responded to tapering doses of prednisone and pyridostigmine. After two months she felt that her strength, endurance and vision were no worse than before the accident. (Pease, W.S., Lagattuta, F.P.: *Arch Phys Med Rehabil* 1987:68(9):568-70.)

This study compared 116 patients treated for low back syndrome at a pain clinic with 72 patients with low back syndrome, but without a comprehensive pain management program. A two-year follow-up in 85% of respondents showed active work in 87% of treated patients, compared to 41% work activities in the non-treated group. The latter group also exhibited twice the number of back surgeries than the pain clinic managed patients. (Mayer, T.G., *et al.: JAMA* 1987:258(13): 1763-67.)

Six hundred eighty-six middle-aged hypertensive men were followed for 12 years with checks for blood pressure control, serum cholesterol levels and cardiovascular disease. The mean in-study BP and serum cholesterol levels were better predictors for cardiovascular disease than the levels at entry. Reductions in blood pressure below 150mmHg systolic and 85mmHg diastolic had no additional benefits. (Samuelsson, O., *et al.: JAMA* 1987:258(13):1768-1776.)

Serum sodium levels of over 148meq/l were noted in 1.1% of hospitalized patients over 60 years of age. Fifty-seven percent had become hypernatremic in the hospital and 43% were hypernatremic at hospitalization. The mean peak serum sodium level was 154meq/l (range 149-182) and mean water deficit was 9% of total body water (range 6%-30%). More than 40 causes were identified, including surgery (21%), febrile illness (20%), infirmity (11%), diabetes mellitus (11%) and iatrogenic factors. Depression of sensorium correlated with the level of hypernatremia. (Snyder, N.A., *et al.: Ann Int Med* 1987:107#3:309-319.)

Four placebo-controlled clinical trials have shown short-term benefits from the second or third line drug, methotrexate, in the treatment of rheumatoid arthritis. Twenty-six percent showed improvement in inflammatory joint reactions, and 39% reported greater improvement in pain compared to controls on non-steroidal anti-inflammatory agents with or without prednisone. Benefits began within one month, reached a maximum after six months and then leveled off. Adverse effects required discontinuance of the drug in one-third of cases. (Tugwell, P.: *Ann Int Med* 1987: 107#3:358-366.)

Use of transdermal clonidine in women with menopausal flashes was evaluated in a double blind study for eight weeks. In 15 patients on clonidine, 80% showed fewer hot flashes compared to 36% on placeboes. Seventy-three percent reported a decrease in severity of flashes compared to 29% in the control group. Sixty-seven percent reported a decrease in the duration of the flashes compared to 21% on placebo. (Nagamani, M., *et al.: Am J Obstet Gynecol* 1987:156: 561-565.)

Most suicide victims had visited their physicians within the previous six-month period prior to death. Patients hospitalized for accidental injuries may be at high risk, since some of these accidents may be disguised suicide attempts. Verbal and behavioral warning signs may be: morbid preoccupation with death; giving away possessions; poor work or school attendance and performance; alcoholism and/or drug dependence. Empathic listening and intervention by the physician, or hospitalization for patients with impaired thinking or severe depression may be indicated. (McAlpine, D. *Mayo Clin Proc* 1987:62(9):778-781.)

Older age, fasting plasma glucose, total plasma cholesterol, and low-density lipoprotein-C were all predictive of fatal heart disease by multivariate analysis. Sixty-two men with non-insulin dependent diabetes were followed for 12 years. Fourteen of these patients died during this period. Neither high density lipoprotein-C nor the LDL/HDL ratio predicted ischemic heart disease death better than the total plasma cholesterol or LDL-C. The adverse effects of hyperglycemia are independent of changes in blood lipids. (Barrett-Connor, E. *et al.: Am J Prev Med* 1987:3#4:206-10.) ◀

What is a Certified Medical Assistant?

By Lesa B. Hildebrand, Ed.M., CMA-C

Many professions offer the opportunity to become credentialed, and the medical assisting profession is no exception. This month we will review the requirements to become a CMA (Certified Medical Assistant).

A medical assistant may become eligible for certification in several ways: (1) graduate from a program accredited by CAHEA (Committee on Allied Health Education and Accreditation); (2) maintain employment for at least one year under the supervision of a physician; (3) instruct a CAHEA-approved medical assisting program.

When one of those eligibility requirements are met, the medical assistant may register for the National Certifying Examination, offered twice a year in January and June. The examination is divided into three major areas: general, administrative, and clinical.

The general area includes such subjects as medical terminology, anatomy, physiology, behavioral sciences, psychology, public relations, professional attitudes and growth, medical law and ethics.

The administrative area includes oral and written communication, bookkeeping, record keeping and filing, office facilities and equipment, and insurance.

The clinical area includes examination room techniques, sterilization procedures, medications, injections and pharmacology, storage and care of supplies and equipment, collection of specimens and laboratory procedures.

The examination is offered by the American Association of Medical Assistants (although candidates need not be members). The National Board of Medical Examiners in Philadelphia acts as a test consultant for the content of this examination. Generally, it takes several months for the examinees to obtain test results. They are mailed a report which itemizes their scores according to the three major areas and lists a composite score with a passing or failing grade. The examinee is also informed about how she/he ranked among other examinees nationwide.

Upon certification, the CMA credential remains current for five years. As of January 1, 1988, recertification will be mandated. Therefore, by January 1, 1993, all certified medical assistants must possess current credentials. The two basic ways to recertify are through continuing education or by retaking the CMA examination. Most continuing education related to the practice of medicine can also be applied towards recertification. New policies and applications for recertification will be available on January 1, 1988. It is important for this information to be available to medical assistants.

Physician advantages to employing a certified medical assistant may be:

- professional competence extended to physicians, coworkers, and patients;
- knowledge of the profession recognized by a national certification process;
- commitment, perseverance and self-confidence;
- willingness to keep up with new technologies.

For further information regarding certification or re-certification please contact: Certification and Continuing Education, AAMA, 20 North Wacker Drive, Suite 1575, Chicago 60606; or Cheryl Hutchison, CMA, ISMA president, 53 Lockhaven, Granite City 62040; or the public relations co-chairpersons: Lesa B. Hildebrand, Ed.M., CMA-C, Triton College, 2000 Fifth Avenue, River Grove 60171; or Lucille Perce, CMA-C, 22W 384 Teakwood, Glen Ellyn 60137. ◀

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Medical Director Retained for ISMS Impaired Physician Program

Violet Eggert, M.D., has been retained as medical director of the ISMS impaired physician program.

Dr. Eggert will administer the educational, intervention and communication elements of the impaired physician program as a full-time staff member of ISMS. She is available to answer questions over the phone or by mail, as well as to speak to medical societies, hospital staffs, medical schools, residency programs and auxiliary chapters on impairment and related topics.

Dr. Eggert's office is part of the division of educational and medical services in the ISMS headquarters. She can be reached through the confidential Physician Helpline number (312/580-2499), as well as the normal ISMS number (312/782-1654).

Physicians in the News

Ronald G. Welch, M.D., Belleville, was presented the Wilson H. West Award by the St. Clair County Medical Society for his dedicated service to the improvement of health care for Illinois citizens and for his enhancement of the public image of the medical profession . . . **Anthony L. Barbato, M.D.,** Oak Park, was elected to the new position of vice president for health affairs and dean of the Stritch School of Medicine at Loyola University Medical Center, Maywood . . . Three Illinois physicians, **Ulrich F. Danckers, M.D.,** River Forest, **Robert Cavallino,** Winnetka, and **George F. Zwicky, Jr.,** Dunlap, were among 104 physicians granted fellowships to the American College of Radiology during its annual meeting in California in September. Fellowships to the College are awarded for significant scientific or clinical contributions to its literature.

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(continued from page 339)

Diagnosis: All of the above

In each case the diagnostic procedure was bronchoscopy. Examination of tissue biopsy in two patients and bronchial brushings in the third demonstrated broad-based budding yeast forms typical of blastomycosis. One of these subsequently grew positive cultures. One patient had a sputum smear positive for blastomycosis.

Blastomycosis was first described by Gilchrist in 1894. He isolated fungal elements from infected skin in 1896.[1] For that reason, blastomycosis has been called Gilchrist's disease. From 1900-1904 early classical work was done at the Rush Medical College and Cook County Hospital in Chicago. Consequently, blastomycosis was known for a number of years as Chicago's disease.[2] Namekagon fever is canine blastomycosis, named for the Namekagon River Valley in Minnesota, an endemic area.[3] Dogs are highly susceptible to blastomycosis, and the disease is more common in this species than in man.[4]

The Organism

Blastomycosis is a noncontagious mycosis caused by *Blastomyces dermatitidis*. The fungus is thermally dimorphic. At room temperature it grows as a spore bearing mycelium and at 37°C as a yeast. Yeast phase growth is characterized by single budding in which daughter cells are attached by a broad base, a characteristic useful in morphological identification. *Blastomyces dermatitidis* is a saprophyte and has been very difficult to isolate. It was first successfully recovered from soil in 1949, but it was not until 1984 that the organism was actually recovered from a suspected source of an outbreak of human disease. Such difficulty implies that the ecologic niche of this fungus is quite restricted. It favors moist, wooded areas with abundant animal droppings. It is likely that the fungus can grow as a mycelium and produce infective spores only under specific conditions of humidity and temperature. The endemic areas are microfoci of very high risk of infection interspersed among large areas where the risk of infection is small or nonexistent. Relatively intimate contact with an infective site is probably necessary to acquire infection.[5]

Incidence and Prevalence

There is no skin or serologic test diagnostic for this infection and as a result the prevalence of subclinical disease is unknown and data for symptomatic disease are scanty. A study at participating facilities of patients hospitalized in 1970 with systemic mycosis showed 53 cases of blastomycosis compared to 1,304 cases of histoplasmosis, demonstrating the relative rarity of systemic blastomycotic infection.[5] The annual incidence in Wisconsin from 1973-1982 was .48 cases per 100,000, with a total of 235 cases reported.[6]

Epidemiology

Blastomycosis is more prevalent in the Southeast, Mississippi River basin and Great Lakes states. It has also been described in South America, Africa and India. Data on the incidence of asymptomatic infections have been derived from only a few studied epidemics or cluster outbreaks. As of 1984 there had been five such epidemics reported, for a total of 46 cluster related cases. In 1986 the largest reported epidemic occurred in northern Wisconsin, where 48 people were infected. Twenty-six of those infected were asymptomatic.[7]

The infected patient populations have often been in wooded areas and include hunters, canoeists and campers. Clinical illness is most common in middle-aged men, but studies demonstrate infection to be independent of age or sex.[5,7]

Pathology

The portal of entry is always the lungs. Incubation time ranges from 21-106 days with a median 33-45 days. There may be resolution of acute primary infection, progression to chronic infection with or without systemic dissemination, or rarely, fulminant progressive pulmonary disease with or without systemic dissemination.[5] Adult respiratory distress syndrome has been considered an opportunistic response, occurring primarily in dehabilitated or immunocompromised patients.[8] Some case studies suggest a mechanism of endogenous reactivation similar to tuberculosis, although reactivation probably occurs less frequently than chronic progression.[9]

Blastomycosis is both a suppurative and granulomatous disease. The primary infection is an initial stage of acute suppurant inflammation followed by more chronic granulomatous infection resembling tuberculosis. Initial inflammation of the hilar nodes accompanying parenchymal involvement—a primary complex—is much rarer in blastomycosis than in tuberculosis or histoplasmosis. Granulomas in chronic infection are typically of the noncaseating giant cell type surrounded by large areas of necrosis. Occasionally, when unaccompanied by necrosis, they resemble sarcoid. Infection of the skin provides the most characteristic tissue response. There is marked hyperplasia of the epithelium with formation of microabscesses. Histologically it is somewhat similar in appearance to carcinoma.[10]

Clinical

The disease has a wide variety of clinical manifestations, ranging from symptomatic self-limited pulmonary involvement to fulminant-disseminated disease in multiple organ systems. Most commonly involved are the lungs, skin, bones, and the male genitourinary tract.[10]

Primary pulmonary infection (acute blastomycosis) produces no symptoms in up to one-half of patients.[7] Symptomatic patients usually have a self-limited illness with flu-like symptoms. These include cough, purulent sputum, pleuritic chest pain, myalgia, arthralgia, and fever. Acute pulmonary disease usually resolves in three to four weeks without treatment, with infiltrates on radiographs resolving in two to four months.[11] Chronic pulmonary disease may be asymptomatic, or produce cough, hemoptysis, weight loss and low grade fever. Bronchitis is present in up to one-third of cases, and may account for rapid endobronchial spread.[10] The reported incidence of pleural involvement is highly variable. Effusion is reported in 7%-15%,[12] local pleural reaction has been reported in 33%,[13] and 88%[12] of patients with chronic pulmonary disease.

Extrapulmonary dissemination occurs secondary to hematogenous spread from the lungs and can occur in any organ of the body, even in the absence of obvious lung disease. The frequency of dissemination was 58% in one study. Thirty-nine percent had extrapulmonary disease only and 19% had concomitant pulmonary disease.[14] Only 60% of patients with systemic infection demonstrate significant radiographic abnormalities.[15] The most frequent extrapulmonary site is the skin, with a 48%[10] to 60%[15] incidence reported in retrospective studies of chronic infection. Skin disease begins as a pustule or nodule and may progress to a verrucous, ulcerated lesion with heaped or irregular borders. Skin lesions are characteristic for blastomycosis, although some may be mistaken for carcinomas. Bone lesions occur in 8%-60% of cases.[10,15]

The male genitourinary tract, particularly the prostate, is another favored site, with involvement in 16%[15] to 38%[10] of patients, and may produce dysuria or pyuria.

Central nervous system involvement occurs in 5%-6%,[10] as a meningitis or encephalitis. Adrenal involvement causing adrenal insufficiency is rare.

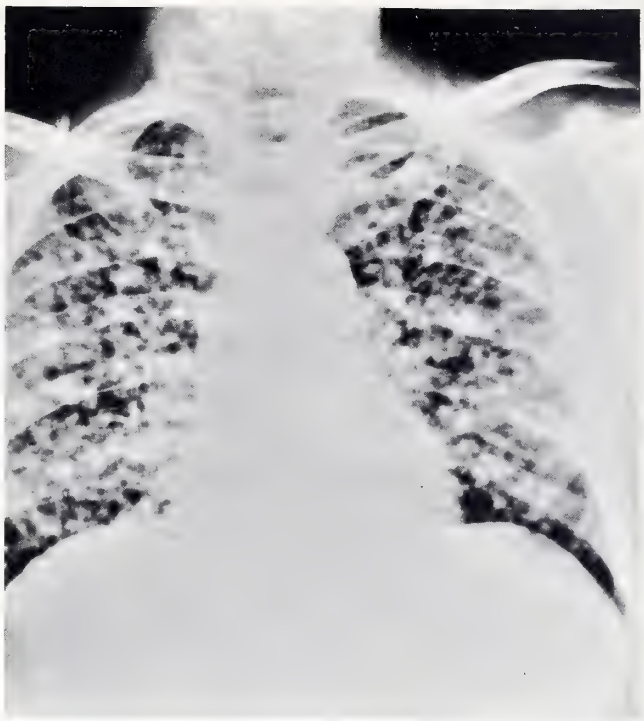


Figure 4
Blastomycosis appearing as numerous bilateral pulmonary nodules.

Radiology

The radiographic appearance of pulmonary blastomycosis is highly variable and nonspecific. Air space consolidation is the most frequent abnormality in both acute and chronic disease (20%[2] to 44%[1,11]), varying in size from small patchy to extensive confluent areas, with segmental distribution more frequent than lobar.[1] A mass-like appearance occurs in 5%[2] to 26%[1] of acute and chronic forms. (Figures 1,2) Some cases are diagnosed at thoracotomy for suspected malignancy. Interstitial patterns occur in 19%[1] to 27%.[11] This is more prevalent in chronic than acute disease. A miliary pattern has been associated with acute rapidly progressive disease in dehabilitated patients.[16] Figure 4 is an example of blastomycosis appearing as multiple pulmonary nodules. Cavitation, primarily in the upper lobes, occurs in chronic disease with reported frequency of 11%[1] to 25%.[15] Fibrosis and volume loss occur in chronic disease, more frequently in the upper lobes. Local pleural reaction and effusions occur with variable frequency. Hilar adenopathy is not a prominent feature of either acute or chronic disease.

Bone lesions are osteolytic, sometimes with sclerotic margins. Most commonly they occur in the axial skeleton and long bones. Septic arthritis, usually monarticular, is secondary to contiguous extension of osteomyelitis or via hematogenous spread.

Laboratory

Definitive diagnosis is made by culture of specimens or by demonstration of characteristic organisms in tissue samples or smears. Multiple sputum specimens are often necessary in order to obtain positive cultures. Cultures are slow growing, and usually therapy is begun on the basis of morphologic identification of characteristic yeast forms.[12]

The skin test is not sensitive or specific, as cross reactivity occurs with histoplasmosis. In addition, a positive response may not be enduring, thus rendering it of little value in assessing the existence of past infection.[16]

Serological tests include complement fixation (CF), immunodiffusion (ID), and Elisa-assays to *Blastomyces dermatitidis* yeast phase antigens. CF has low sensitivity and specificity. Cross reaction occurs with histoplasmosis at a higher frequency than for blastomycosis[17] and also with *C. immitis*. ID to blastomycosis A and B antigens has a much higher specificity rate, although sensitivity in acute outbreaks is low (28%-40%). A new enzyme immunoassay for the A-antigen is more sensitive and achieved positivity rates of 77% in the largest described outbreak of blastomycosis, compared to 28%

for ID and 8% for CF.[7] Reported specificity for the test is 86%-96%.[7,18]

An assay measuring the *in-vitro* transformation of lymphocytes in the presence of a blastomycosis alkali and water soluble antigen (B-A SWS) appears to be the most sensitive test for immunological markers, achieving a positivity rate of 81% in one study.[7] No information concerning specificity is currently available, and the test is still in the investigational stage.

Treatment

Acute pulmonary infection may resolve spontaneously without treatment, and non-progressive disease may be observed closely to resolution without treatment.[5,19] Amphotericin B is the drug of choice for progressive pulmonary, disseminated, or chronic disease. Studies with ketoconazole, an oral antifungal agent less toxic than amphotericin B, suggest that it is an effective alternative in the immunocompetent patient with mild-to-moderate non-meningeal disease.[14,20] Ketoconazole is excreted in the biliary tract, and thus may be less effective in GU infection because of relatively lower concentration of active drug in the urine. A prospective randomized trial demonstrated that a high dose regimen is more effective (100% vs. 79%), but more toxic, than a low dose regimen for at least six months of treatment. It has been suggested that patients start on a low dose regimen with increased dosage for progressive disease.[14] Treatment is recommended until cultures are negative and radiographs show stabilization or resolution. A prolonged post treatment follow-up is necessary to identify relapse. ◀

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Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

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CENTRAL ILLINOIS:
Internal Medicine; Solo Practice. Office is located within 40 miles of two medical schools and one block from Millikin University. There are 2 open staff 400-bed hospitals. The population of the city is 100,000, trade area is 250,000 and 140 physicians. The method of payment is fee-for-service. Contact: Charles F. Downing, M.D., 1067 West Main Street, Decatur 62522; (217) 423-9775. (12)

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CLIFTON:
Board certified OB/GYN. 70 miles south of Chicago. Rural community hospital. Service area population 10,000. Excellent financial benefits, including guaranteed income, modern office space adjacent to hospital, staffing and moving expenses. Contact: Dianne Soucie, Administrator, Central Hospital, P.O. Box 68, Clifton 60927; (815) 694-2392. (10)

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(continued from page 340)

the Board approved the following:

Existing HOD Actions

- Retain Professional Policy Manual Statements on: Abuse and Neglect of the Elderly; Firearms; Health Maintenance Organizations; Hospital and Medical Staff Committees; Indigent, Care of the; Informed Consent; Judiciary and Legal Reform; Medical Representation in Government Planning; Medical Staff Participation in Accreditation Activities; Medical Staff Participation in Hospital Cost Containment Efforts; Medical Supplies, In-Flight; Physicians, Reimbursement of Ambulatory Services; Tobacco Farm Subsidies. Retain Administrative Policy Manual Statements on: Financial Policies; Informing the Membership; Mailing List; Polls, Opinion; Uniform Health Insurance Claim Form.

The Board further agreed to:

- Delete "Medical Staff Membership" from Official ISMS Actions and add the following to line five of the Policy Manual Statement on Joint Committee on Accreditation of Hospitals: "Opposes the development of any JCAH Standard mandating medical staff membership to anyone other than physicians."
- Delete "OSHA Access to Medical Records" from Official ISMS Actions and add following to Policy Manual Statement on Confidentiality: "The ISMS supports the concept that access to individual identifiable employee medical records by employers or government agencies, except as required by law, is contrary to traditional and legal medical practice, in conflict with the patients' best interest, and inimical to public policy.

Existing BOT Actions

The Board also agreed to:

- Retain the following Official ISMS Actions: Good Samaritan Concept; First Year Dues; Travel Reimbursement.
- Retain following amended Official ISMS Actions: Distribution of *IMJ* and Key Man Program.
- Delete following action from Official ISMS Actions: Washington D.C. Board Meeting.

Other Actions

In addressing various other issues, the Board:

- Accepted the June 30, 1987, Financial Statements; July 31, 1987, IMPAC Collection Data; July 31, 1987, Dues Payment Report; and Requests for Changes in Membership Status.
- Agreed that no changes would be effected in the 1988 *IMJ* subscription rates, and also reported that the *IMJ* base page rate had been increased by 7%.
- Agreed to endorse an ISMS resolution to the AMA asking that the AMA develop guidelines and incentives for state and county medical societies in order to encourage and assist these organizations to foster greater participation of FMG's in leadership positions at all levels of organized medicine, subject to amendments by the Illinois delegation subsequent to any discussions which may occur.
- Authorized the Executive Committee to develop a PLI III strategy.
- Authorized the filing of an amicus curiae brief in support of the constitutionality of the 1987 Medical Practice Act, if deemed necessary.
- Ratified the approval of twelve INTRAV travel programs for 1988.
- Approved holding the 1989 Annual Meeting at the Westin O'Hare Hotel April 7-9, 1989.
- Rescinded its previous action to publish a brochure at this time outlining recent changes to Part B Medicare as mandated by the SOBRA legislation.
- Authorized the Chairman of the Board in conjunction with legal counsel to develop an appropriate mechanism by which to communicate information on Maximum Allowable Actual Charge (MAAC) monitoring and compliance options to the membership.
- Authorized appropriate dissemination of information to the membership concerning the contract review service and the $100 fee to be charged so that members will be aware of new cost procedures.
- Deferred consideration on the 1977 and 1979 Board positions on "Physician Extenders" until the position paper titled "Physician Interrelationships with Allied Health Personnel," is available.
- Authorized development of a resolution to delete the ISMS Official Action statement titled "Disaster Teams."
- Agreed to retain the Policy Manual statements titled Disaster Control, Preventive Services, Categorization of Hospitals, Administration of Injections and Drawing Blood.
- Authorized development of resolutions to delete ISMS Official Action statements titled, Involuntary Certification, Hospital Procedures with Mental and Physical Illness and Minimum Standards for Health Insurance Programs.
- Approved the development of a program on disability determinations by ISMS' Committee on Worker's Compensation. This will be part of the Chicago Medical Society's 1988 Midwest Clinical Conference, with no cost to ISMS.
- Approved development and promotion of the 1988 ISMS Physician Games, as long as sufficient funds are raised from corporate sponsors and registration fees to cover the major expenses of the event.

Programs

The Board:

- Accepted the All Member Conference agenda and programs for Saturday, November 7, 1987, at the Hyatt Oak Brook Hotel.
- Agreed to serve as host for a multistate conference of medical society student loan programs with costs supported by outside contributions and registrant fees.

Nominations and Appointments

Various nominations and appointments were approved or ratified by the Board as follows:

- Ratified appointment of Dr. David B. Littman, Highland Park, to the ISMS Planning and Priorities Committee.
- Ratified appointment of Stephen H. Sheldon, D.O., Chicago, to the ISMS Council on Medical Services.
- Ratified nominations of Drs. Otto C. Brosius, Decatur; Irene S. Caruso, Galesburg; Earl E. Fredrick, Jr., Chicago; Joseph B. Perez, Rockford; and Biswamay Ray, Oak Brook, to serve on the Medical Disciplinary Board.
- Ratified nominations of Drs. Dean R. Bordeaux, Peoria; Jere E. Freidheim, Burr Ridge; Arvind K. Goyal, Itasca; Lawrence L. Hirsch, Northbrook; and John M. Holland, Springfield, to serve on the Medical Licensing Board.
- Ratified nominations of Drs. E. Richard Blonsky, Chicago; Hazel Mrazek, Riverside; and Raymond Teplitz, Berwyn, to serve on the Drivers License Medical Advisory Board.
- Ratified nomination of Dr. George T. Wilkins, Jr., Edwardsville, to serve on the Illinois Comprehensive Health Insurance Board of Advisors.
- Selected Drs. Raymond Dieter, Alfred Kiessel and Michael Snyder to serve on the Insurance Trust for sponsored member insurance programs. This Board will report to the ISMS Insurance Committee.

Special Guest

Dr. Kiessel presented a plaque to Dr. J. William Roddick, Jr., to commemorate his nine years' service as chairman of the *Illinois Medical Journal* Editorial Board.

Informational Reports

Informational reports were presented by the Committee on Constitution and Bylaws, Governmental Affairs Council, Council on Public Relations and Membership Services, Committee on CME Accreditation, Planning and Priorities Committee, ISMIS, ISMIE, IMPAC, AMA Delegation Chairman and Resident Physicians Section.

Next Meeting

The next Board meeting was set for 10:30 a.m., November 6, 1987, at the Hyatt Oak Brook Hotel. ◀

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OBSTETRICIAN/GYNECOLOGIST—Marshfield Clinic is seeking a board certified or eligible obstetrician/gynecologist to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Marshfield Clinic is a 250-physician, multi-specialty private group practice offering a very competitive salary and fringe benefit package. Send curriculum vitae and references to: Bob Peterson, Director, Regional Centers, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449; or you may call collect at (715) 387-5498.

FAMILY PHYSICIAN NEEDED—Immediate need for BC/BE family physician to join two established family physicians in private practice in N.W. Iowa community of 5,000. Modern clinic across the street from JCAH hospital. Excellent salary and fringe benefits

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GENERAL INTERNAL MEDICINE—Marshfield Clinic is seeking a board certified or eligible general internist to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The center currently includes three internists. The clinic is adjacent to a 110-bed JCAH accredited hospital. Marshfield Clinic is a 250-physician, multi-specialty private group practice offering a very competitive salary and fringe benefit package. Send curriculum vitae and references to: Bob Peterson, Director, Regional Centers, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449; or you may call collect at (715) 387-5498.

PRIMARY CARE PHYSICIAN to do care for busy general surgeon. Fourteen year established practice in town of 4-5000 with medical market area of 40,000. Prefer board certified in general practice or internal medicine. Send resume to: P.O. Box 101 Coal City, IL 60146; Attn: Resume.

TWENTY-NINE PHYSICIAN multispecialty clinic located in desirable east central Wisconsin location is seeking board certified or board qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D. F. Sweet, M.D., Fond du Lac Clinic, S.C., 80 Sheboygan Street, Fond du Lac, Wisconsin 54935.

INTERNAL MEDICINE. Board certified or eligible to join 12 physician, expanding, multi-specialty practice in northern Wisconsin. Clinic adjoins JCAH hospital. Rural location with abundant outdoor recreational opportunities, small four year college. Excellent salary and benefits. Call collect (715) 532-6651 or send curriculum vitae with names of references to: John C. Smylie, Administrator, Marshfield Clinic, Ladysmith Center, 906 College Avenue W., Ladysmith, WI 54848.

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CHAIRPERSON: Department of Surgery. Saint Joseph Hospital and Health Care Center, a 400 bed medical school affiliated hospital, seeks a full time chairperson for its department of surgery. The senior-attending, board certified candidate will direct the department, expand its services and assure quality patient care. Demonstrated accomplishments in surgery, surgical education and administration are essential. Submit a C.V. to Irwin Horwitz, M.D., Chairman, Search Committee. Saint Joseph Hospital and Health Care Center, 2900 North Lake Shore Drive, Chicago, IL 60657.

BOARD CERTIFIED or eligible psychiatrist for inpatient and outpatient treatment. Interest in alcohol and substance abuse a plus. Excellent opportunity to join four-member department in multispecialty medical clinic. Close to university and metropolitan areas in south-central Wisconsin. Excellent salary and benefits. Contact Jane C. Smith, M.D., The Monroe Clinic, Monroe, WI 53566; (608)328-7321.

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SOUTHEASTERN IOWA—Seeking director, full-time, and part-time physician for new 50 bed hospital emergency department. Attractive hourly compensation and malpractice insurance provided. Benefit package available. Contact Emergency Consultants, Inc., 2240 S. Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795, or in Michigan 1-800-632-3496.

FAMILY PRACTICE/INTERNIST opportunity-needed for mid-Illinois community. Well equipped JCAH hospital close to major hospitals and medical schools, liberal guarantee and benefits. Interested parties send C.V. and inquiries to Chief of Medical Staff, Mason District Hospital, 520 Franklin, Havana, IL 62644.

GENERAL SURGEON: Recent medical retirement leaves opening for fourth surgeon to join three other board certified surgeons practicing general, thoracic and vascular surgery. Located in north central Indiana. Interest in endoscopy and colo-rectal surgery desirable. Send resume to: Box #2083, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

EMERGENCY MEDICINE. For emergency physician who possesses excellent clinical and trauma skills within a group of 7 emergency room physicians located in beautiful northwest Wisconsin area. Please send C.V. to: Dr. M. Jaghlit, 900 W. Clairemont Ave., Eau Claire, WI 54701; or call (715) 839-4404.

STAFF PHYSICIAN—Highly reputable Chicago clinic group specializing in treating venous disorders by unique compression injection treatment needs staff physicians with 2-5 years experience preferably in internal medicine or general practice. Offer competitive compensation package and opportunities for growth. Many opportunities for relocation to other metropolitan areas are available. If you are tired of working evenings and weekends and are motivated to build a practice with a leader in varicose vein treatment, please send CV and recent financial statement to Medical Director. Box 2089, c/o *Illinois Medical Journal,* Twenty N. Michigan Avenue, Suite 700, Chicago, IL 60602.

OB/GYN, FAMILY PRACTICE, General Internist, ENT & Pediatrician—needed for two-hospital, historic river town of 20,000. Drawing area of approximately 60,000 with new 19,000 acre recreational lake. Unlimited potential. Contact Carol Murphy, Physician Recruitment, 623 Broadway, Hannibal, MO 63401, or call 314-221-3107.

FAMILY PHYSICIAN for established south suburban Chicago group practice clinic. BE/BC. Salary guarantee with incentive and benefit package. Reply to Box #2090, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

OB/GYN, BOARD CERTIFIED or eligible, to join highly progressive, rapidly growing practice. Normal and high risk obstetrics emphasized along with highest levels of infertility care (microsurgery, GIFT, IVF, Laparoscopic Laser Surgery), as well as extensive gynecology and surgery practice. Easy lake country or Milwaukee suburban living. Salary and guarantees to meet your needs with opportunity for partnership in one year. Available July, 1988, or earlier. Contact Matt Meyer, M.D., Women's Health Care, S.C./Milwaukee Regional Fertility Center, 426 W. Main Street, Waukesha, Wisconsin 53186, 414-549-1333.

FAMILY PRACTICE FULL-TIME Faculty Position for ABFP certified family physician in 15 resident training program. Progressive program with young faculty and accreditation to the University of Illinois College of Medicine at Peoria. Responsibilities include: resident supervision, patient care, and some administrative duties. Interest in obstetrics preferred. Family Practice Center is adjacent to 800 bed hospital in heart of central Illinois. Metropolitan population of 300,000. Seven supporting residencies with faculty in all major subspecialties. Send curriculum vitae to Richard H. Leu, M.D., Director, Family Practice Residency Program, Saint Francis Medical Center, 624 N.E. Glen Oak, Peoria, Illinois 61637.

INTERNAL MEDICINE: Northwest Illinois community of 35K with drawing area of 80K. Board certified physician to join established internist. Supported by 200+ bed hospital in family-oriented community with excellent neighborhoods and schools. Located 3-½ hrs from Chicago and 45 minutes from Peoria. Competitive compensation package. Contact Amy Evitts. Tyler & Co., 9040 Roswell Rd., Atlanta, GA 30350. Call 404-641-6411.

PSYCHIATRIST for busy hospital/office private practice. Immediate opening with opportunity for partnership. Northwest Chicago suburbs. Forward C.V. to Box #2072, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GROUP HEALTH, INC. SEEKS BC/BE associates in: cardiology, internal medicine and obstetrics/gynecology. A balanced life style includes the enjoyment of practicing quality medicine in a 30 year old prepaid, multispecialty setting, located in one of the nation's leading metropolitan areas, working in excellent facilities, participating in comprehensive benefits with flexible compensation and teaching opportunities available. Please send CV to: Jerry Hess, Group Health, Inc., 2829 University Avenue South East, Minneapolis, MN 55414.

NEUROLOGIST: Board Certified, (20 hours weekly), 1,000 bed chronic disease care hospital including 122 neurology beds, Must be trained in electromyography, electroencepohalography and evoked potentials. Must be willing to teach medical school students and participate in the continuing medical education programs. Assist with research and provide neurological coverage for inpatients and outpatients. Supervisory skills necessary for training resident physicians. Some knowledge of psychiatry required. Excellent benefits including malpractice, hospitalization insurance, vacation, holidays and sick days: FREE life insurance; optional deferred compensation plan. Reply with curriculum vitae to: Medical Administration, Oak Forest Hospital, 15900 South Cicero Avenue, Oak Forest, IL 60452.

PHYSICIAN: Fully accredited 1,000 bed county chronic disease and rehabilitation facility affiliated with two medical schools is seeking a full-time board certified physician on a temporary basis in the internal medicine department. Must have completed residency training and possess current license. Direct all inquiries with curriculum vitae to: Medical Administration, Oak Forest Hospital, 15900 South Cicero Avenue, Oak Forest, IL 60452.

UNOPPOSED PRACTICE OPPORTUNITY for rheumatologist, board eligible or board certified to associate with ABIM internist in expanding medical practice, competitive salary guaranteed with incentive formula, full partnership at the end of one calendar year. Two 400 bed hospitals in city of 100,000, drawing area 150,000. Midwest. No other rheumatologist in town. Start July, 1988 or earlier. Send CV and inquiries to Box #2077, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DIRECTOR, OCCUPATIONAL HEALTH: Opportunity to direct growing occupational health service in large midwestern city. Position offers a variety of challenges in conjunction with joint programs in sports medicine and executive fitness. BE/BC with 1-2 yrs experience a plus. Competitive salary, incentives, and a negotiable benefits pkg. Contact Jim Davis. Tyler & Co., 9040 Roswell Rd, Atlanta, GA. Call 404-641-6411.

ILLINOIS (Chicago, West & Central Areas): Seeking Emergency Medicine physicians for full time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

SITUATIONS WANTED

DIAGNOSTIC RADIOLOGIST: Board certified, interventional and imaging fellowships, experienced in all modalities, seeks locums short term. Available most weekends, some weeks including weekdays. Reply to Box #2051, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MEDICAL ASSISTANTS, Medical Doctors, medical secretary/receptionist, office manager/bookkeeper, insurance biller, laboratory/x-ray technicians for Chicago and suburbs. Call American Medical Personnel, Ms. Christy at (312) 337-4221.

BOARD CERTIFIED INTERNIST critical care seeks to buy primary care practice or to be partner of near retiring physician. Reply Post Box No. 1716, Marion IN 46952.

BOARD-CERTIFIED, residency trained family practitioner seeks position in Illinois with group of similarly trained physicians. Thirty years old with one year practice experience including flexible sigmoidoscopy and stress EKG. Send details to Box #2076, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED OB-GYN available for group or hospital-based practice; will consider salaried position, etc. Reply to Box 2087, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED GYNECOLOGIST: Seeks partnership in Chicago. Fellowship in family planning, gyn-oncology. Experienced in liposuction and vein injection and other outpatient surgery. Call at night: (312) 527-4346. Reply to Box 2088 c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box #2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE, LEASE OR RENT

USED MEDICAL EQUIPMENT. Complete suites or individual pieces bought and sold. Also examination tables, O.R. tables, O.R. lights, EKG's, therapeutic and diagnostic ultrasound, diathermy surgical instruments, microscopes, etc. Please call or write Robert Shapiro at 2618 W. Peterson Avenue, Chicago, IL 60659; (312) 743-3900.

MEDICAL BUILDING and practice for sale. Chicago northwest side. Grossing $72,000 annually, includes office equipment, supplies, and pharmacy business. Relocating. Spanish speaking doctor will stay to introduce patients. Call (312) 907-2223—24 hours.

OFFICE SPACE for rent in Hanover Park. Greenbrook Professional Center, Greenbrook and Lake Sts. Special incentives offered. Call (312) 830-2900.

FAMILY PRACTICE for sale. 25 years old. City of 12,000 ten miles from St. Louis, Missouri. No OB. Grossing $360,000.00 yearly. Price- one year net income. Reply to Box #2073, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE: Medical building Harlem/Belmont. 6 yrs new. Nets $100,000. Park 40 cars. No money down. Call Mr. Eisenberg Baldwin & Associates (312) 472-3800.

MEDICAL SUITES AVAILABLE: 1300 S.F. in deluxe new medical building in prime Palos location for March, 1988. Physicians may design own floor plan. Call (312) 430-1000.

FOR SALE: Pediatric practice, central Illinois. 2 universities, strong economy, auto-plant operate in 1988. Reach six figures gross. Evening (309) 452-0863.

WITHOUT COST to you, take over family practice. Rent: 820/month. Single bldg.; East Moline, (Quad Cities); (309) 755-2079.

MODERN 3 BEDROOM tri-level residence, with living room, family room-kitchen area, located on 65 acres outside Centralia, Illinois. The acreage is improved with stables, feed lot, metal outbuildings, fenced pasture and pond. Some of the remaining acreage is in cultivation. Three miles or less from schools, churches, hospital and shopping. Excellent opportunity for horse farm enthusiast. Please contact either (618)-532-7426 by telephone or P.O. Box 179, Mascoutah, IL 62258, in writing for further information or appointment to visit this real estate.

FOR SALE: Established busy south side public aid family practice and building. Two rented two-bedroom apartments included. Price $96,000. Call Dr. Polussa (312) 684-3300.

OFFICE SPACE FOR RENT. Busy far south east Hegewisch Medical Building, 600 square feet. Share common area with five doctors, pharmacy. Suitable for specialties. (312) 646-2343 ext. 3762.

LONGBOAT KEY (Sarasota) Florida—Newly redecorated 2 bedroom, 2 bathroom condo-

minium. Balcony with direct Gulf frontage and view. Available February 1-May 31. Thirty day minimum. Swimming pool. Golf nearby. Security Deposit. Manager on premises. $3,000 per month (Jack, 815-562-8754).

NEAR CHAMPAIGN & DECATUR. Owner anxious to sell his general practice. Grossing $150,000. Busy practice, low overhead. Asking $68,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

SOUTHEAST SIDE CHICAGO: General practice located near Jackson Park Hospital. Grossing $140,000, asking $40,000 or purchase practice and real estate for $96,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

MEDICAL PRACTICE SALES. At Medidentic we have the expertise and the contacts to sell your practice. Buyers and sellers, see our ad on page 373. Medidentic Practice Sales—(312) 696-0220.

PHYSICIAN'S MEDICAL suite for rent. Southwest side. Call (312) 582-2660.

AVAILABLE FOR RENT 1988 Modern established pediatric medical suites, (1800 sqft). in prestigeous Medical Center, 6450 N. California, (corner Arthur). Pharmacy, x-ray office, complete laboratory on premises. Spacious waiting room and 6 day full time experienced receptionists—switchboard operators to handle appointments, paid by building. Parking lot. Reasonable rent. Will divide space if requested. For appointment call: (312) 764-4000 or (312) 338-5089.

IMMEDIATE OPENING in family practice. Thriving practice available due to imminent retirement, located in Illinois mideastern city. Guaranteed salary plus incentive, liberal benefits. Send C. V. to R. D. McKinley, Farris & Associates, Inc., 16216 Baxter Road, Suite 200, Chesterfield, MO 63017.

AVAILABLE GENERAL Surgery Practice. Physician Retirement. Outstanding opportunity. High Income. Modern hospital and university nearby. Call (217) 234-6447 or 235-4525 after 5:00 p.m.

INTERNAL MEDICINE and General Practice for immediate sale in two small Indiana towns bordering eastern Illinois, 100 miles from Chicago, grossing $175,000/1yr with potential for much more growth. No OB, no surgery, no HMOs. Low overhead. Price & terms negotiable. Can easily be run by a general surgeon, too, with considerable increase in gross income. Call (414) 782-0651 anytime and leave message with phone number.

FOR SALE—well established general practice located in twin cities of central Illinois with universities in each. Excellent opportunity for young physician interested in primary care medicine. Expect population increase with new auto plant. Reply to Box 2091, c/o the *Illinois Medical Journal,* Twenty North Michigan Ave., Suite 700, Chicago, IL 60602.

MISCELLANEOUS

DISCOUNT HOLTER SCANNING Services starting at $35.00. Spacelabs holter recorder (cassette) available from $1275.00. Cardionostic holter recorder (cassette) available from $995.00. Smallest and lightest holters update. Fast service (24-48 hrs turn over). Hookup kits starting at $4.95. Special introductory offer of three free tests with any purchase or lease of the recorder. Cardiologist overread available for $15.00. If interested call 1-800-248-0153.

MEDICAL TRANSCRIPTION: Federal disability letters, consultations, progress notes; 24 hour toll-free phone-in dictation service; fast turn-around time; fee per line. Certified Medical Transcriptionists (AAMT), qualified in all specialties. Hagedorn Secretarial Service, Inc., "Specialists in medical transcription"; (312)296-0034.

FOR PHYSICIANS and residents: Unsecured signature loans $5,000-$60,000. No points or fees. Competitive rates-level payments. Up to six years to repay. Deferred principle option, confidential-rapid processing. For information and application call toll-free (800)331-4952, MediVersal Dept. 114; or MediFinancial Services (512) 836-9126, Harper.

HEALTH CARE PERSONNEL Consulting, Inc., a division of The Health Care Group, specializes in valuation and sales. We have practices currently available in the following specialty areas: Allergy, dermatology, family practice, internal medicine, ophthalmology, pediatrics, psychiatry, psychology, radiology and urgent care. For more information regarding selling or buying a medical practice, contact our brokerage division at The Health Care Group, 400 GSB Bldg., Bala Cynwyd, PA 19004; or call (215) 667-8630.

"I Quit Clinics"

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

December 1	Rush North Shore Med. Ctr.	*Skokie*
To Be Announced	Amubtal	*Crystal Lake*
To Be Announced	Copley Memorial Hospital	*Aurora*
To Be Announced	Delnor Community Hospital	*Geneva*
To Be Announced	Dreyer Clinic	*Aurora*
To Be Announced	Highland Park Hospital	*Highland Park*
To Be Announced	Hinsdale Sanitarium and Hospital	*Hinsdale*
To Be Announced	Memorial Hospital for McHenry County	*Woodstock*
To Be Announced	Mendota Community Hospital	*Mendota*
To Be Announced	Northern Illinois Medical Center	*McHenry*
To Be Announced	Resurrection Hospital	*Chicago*
To Be Announced	Sherman Hospital	*Elgin*
To Be Announced	West Town Public Health Clinic	*Chicago*

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Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

WARNING
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. [illegible] potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations [illegible] Cumulative effects of the drug may develop in patients with impaired renal function. [illegible] when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. [illegible] of nondepolarizing muscle relaxants such as tubocurarine. [illegible] histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering [illegible]

[illegible] hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it [illegible] measures and 'Dyazide' should laboratory values reveal elevated [illegible] hyponatremia. Concurrent use with chlorpropamide may increase [illegible] toxicity.

Adverse Reactions: [illegible] reported in a few patients on 'Dyazide', although a causal [illegible]

Supplied: 'Dyazide' is supplied as a red and white capsule, in [illegible]

a product of
SK&F CO.
[illegible]

© SK&F Co., 1987

Some New Year's Resolutions



This issue sums up the year's activities of our Society. It is the season to be generous and reflective, and also to make resolutions. I ask you to be generous with me and my resolutions. Perhaps you can use them too.

I will not lose my sense of humor.

I will try not to repeat lawyer jokes.

When my hospital privileges are suspended for not doing my records, I promise to make up right away.

When my MAAC calculations, profiles and violation warning letters start flying around, I will not put them in the round file.

I will read the ISMS journal and rip out and give the front blue sheet on insurance concerns to my office staff.

I will not argue with nurses (I'll just do what they tell me to do).

If my spouse tells me to "slow down," I will understand that she has more to say, and I will listen harder.

Patients will wonder what came over me when I give them more time by asking, "How are things with your family?" and, "Is there anything else you would like to talk to me about?"

I won't let my clothier sell me plaids, new styles and fad clothes that he can't get anybody else to buy.

If I run into a medical student, I won't say, "Why are you doing such a dumb thing?"

I won't forget Aristotle's observation, "Medicine is an art with a good to achieve, not a science with a truth to perceive."

I will help my fellow doctors and, thus, my profession even though my ego makes it hard to do so.

If the *Enquirer* headlines that AIDS virus has been found in cows milk, I won't believe it or repeat it.

I will give a day's earnings in 1988 to the fight for caps in Illinois.

I will patiently wait for Dr. Sammons (AMA) and Dr. Hanlon (ACS) to kiss and make up.

Comments from my internist friends about their need for "cognitive" fees will not be laughed at (openly).

I will continue to believe that the government will see the wisdom of the carrot part of the carrot and the stick philosophy.

I will shine my shoes more often.

I will stop buying more life insurance of dubious quality, buy a cemetery plot and set my affairs in order so that there will be less chaos if I go early on.

When the QA committee sends me a letter, I will answer it coherently and change my ways.

I will give more time and affection to my family.

And last but not least, I will continue to enjoy practicing medicine to the best of my ability.

You may have more to add or subtract from the above, but don't dismiss them. It's easy to be flip and cynical, and most of us doctors—doing what we do—are very good at trading barbs. But "times—they are a changin'," and a lot of people resent us, our joy in our profession and the expenses involved in medical care. We must be cognizant of this and remain aware that we must live up to the ethical ideals of our ancient practice:

I do solemnly swear by that which I hold most sacred:
That I will be loyal to the profession of medicine and just and generous to its members;
That I will lead my life and practise my art in uprightness and honor;
That into whatsoever house I shall enter, it shall be for the good of the sick to the utmost of my power, I holding myself aloof from wrong, from corruption, and from the tempting of others to vice;
That I will exercise my art solely for the cure of my patients, and will give no drug, perform no operation for a criminal purpose, even if solicited, far less suggest it;
That whatsoever I shall see or hear of the lives of men which is not fitting to be spoken, I will keep inviolably secret.
These things I do promise, and in proportion as I am faithful to this my oath may happiness and good repute be ever mine—the opposite if I shall be forsworn.

(circa 400 B.C.)
The Oath of Hippocrates



Edward J. Fesco, M.D.
President

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Registration and Education

Medical and Controlled Substance License Renewals

The Department of Registration and Education and the federal Drug Enforcement Administration have notified ISMS that their records indicate that several thousand physicians have not renewed their medical or controlled substance licenses or DEA registrations. Physicians who do not renew their licenses or DEA registrations will be considered as practicing medicine and prescribing controlled drugs without necessary licenses, and may face civil penalties in the form of fines or injunctive relief by state and federal authorities.

Illinois and federal laws state that physicians are responsible for notifying the DRE and the DEA of any address changes or decisions to retire. In certain instances mail from these agencies has not been forwarded to a new address by the post office. In these situations, the government agencies are presently not required to seek out physicians.

In February, the DEA will begin initiating actions against physicians who do not contact the Chicago office.

If you have not renewed your Illinois medical or controlled substance license, or your federal DEA registration, contact the local offices immediately for assistance:

Illinois Department of Registration and Education
Medical Section
320 West Washington
Springfield, IL 62786
217/785-0800

Drug Enforcement Administration
500 Dirksen Federal Building
219 S. Dearborn
Chicago, IL 60604
312/353-1234

(Source: Correspondence from DRE and DEA offices)

Medical Disciplinary Orders

- *Thomas Auerbach* (lic. # 036-029028 & 003-036-029028)
  Effective August 18, 1987, Dr. Auerbach's medical and controlled substance licenses were indefinitely suspended.
- *Zoltan Braun* (lic. # 036-036195 & 003-036-036195)
  Effective August 18, 1987, Dr. Braun's medical and controlled substance licenses were indefinitely suspended.
- *Philip Gradolph* (lic. # 036-038693)
  Effective August 18, 1987, Dr. Gradolph's medical license was suspended for 90 days.
- *Richard Z. Gumm* (lic. # 036-051237 & 003-036-051237)
  Effective June 18, 1987, Dr. Gumm's medical and controlled substance licenses were placed on probation for three years.
- *Gerald Hanley* (lic. # 036-041765 & 003-036-041765)
  Effective August 18, 1987, Dr. Hanley's medical and controlled substance licenses were indefinitely suspended.
- *Robert S. Levine* (lic. # 036-028894)
  Effective August 15, 1987, Dr. Levine's medical license was reprimanded, but was restored to full status without restrictions.
- *Cipriano C. Livas* (lic. # 036-046994 & 003-036-046994-1)
  Effective August 31, 1987, Dr. Livas' medical and controlled substance licenses were suspended.
- *Preston Walker Sawyer* (lic. # 036-021942)
  Effective August 20, 1987, Dr. Sawyer's medical license was suspended.
- *Richard B. Stone* (lic. # 036-043480)
  Effective August 18, 1987, Dr. Stone's medical license was indefinitely suspended.

(Source: Orders received from the Director of DRE)

From the Illinois Department of Public Health

AIDS Information Packet

There are changes in the Information/Resources document which was in the AIDS packet recently sent to all Illinois physicians by ISMS. Please make the following changes in your listing:

Page 1: AIDS Hotlines (and other sections)
—Delete all listings of the "AIDS Assistance Association." This group no longer exists.
—Change "AIDS Pastoral Committee" to "AIDS Pastoral Care Network."

Page 3:
—Delete the "AIDS Foundation" from the Pediatric AIDS listings.
—Under the Pediatric AIDS listings, add Children's Memorial Hospital, 312/880-4187.
—Under the Social Support Services, change the phone number of Children's Memorial Hospital to 312/880-4187.

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IN HYPERTENSION

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- **Excellent patient acceptance reduces dropouts**

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Please see accompanying brief summary.
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(terazosin hydrochloride tablets)

Brief Summary

CLINICAL PHARMACOLOGY: Pharmacodynamics: Clinical studies of terazosin used in once-a-day (majority) and b.i.d regimens with total doses usually in the range of 5-20mg/day, in patients with mild or moderate hypertension. Because terazosin, like all alpha antagonists, can cause large falls in blood pressure after the first dose or first few doses, the initial dose was 1mg in virtually all studies, with subsequent titration to a specified fixed dose or titration to a specified blood pressure end point.

Blood pressure responses were measured at the end of the dosing interval (usually 24 hrs.) and effects were shown to persist throughout the interval, with usual supine responses 5-10mmHg systolic and 3.5-8mmHg diastolic greater than placebo. The responses in the standing position tended to be somewhat larger, although this was not true in all studies. The magnitude of blood pressure responses was similar to prazosin and less than hydrochlorothiazide (in a single study). In measurements 24 hrs. after dosing, heart rate was unchanged.

Limited measurements of peak response (2-3 hrs. after dosing) during chronic terazosin administration indicate that it is more than twice the trough (24 hr.) response, suggesting some attenuation of response at 24 hrs., presumably due to a fall in blood terazosin concentrations at the end of the dose interval. This explanation is not established with certainty and is not consistent with the similarity of blood pressure response to once-a-day and b.i.d. dosing. With the absence of an observed dose-response relationship over a range of 5-20mg, i.e., if blood concentrations fall to the point of providing less than full effect at 24 hrs., a shorter dosing interval or larger dose should lead to increased response. Measure blood pressure (BP) at the end of the dose interval; if response is not satisfactory, patients may be tried on a larger dose or b.i.d. regimen. The latter should be considered if side effects, such as dizziness, palpitations, or orthostatic complaints, are seen within a few hours after dosing.

The greater BP effect associated with peak plasma concentrations (first few hours after dosing) appears somewhat more position-dependent (greater in the erect position) than the effect of terazosin at 24 hrs. In the erect position there is a 6-10 bpm increase in heart rate in the first few hours after dosing. During the first 3 hrs. after dosing 12.5% of patients had a systolic pressure fall of 30mmHg or more from supine to standing, or standing systolic pressure below 90mmHg with a fall of at least 20mmHg, compared to 4% of a placebo group.

INDICATIONS AND USAGE: Indicated for the treatment of hypertension.

CONTRAINDICATIONS: None known.

WARNINGS: Syncope and "First-dose" Effect: Terazosin, like other alpha-adrenergic blocking agents, can cause marked hypotension, especially postural hypotension, and syncope in association with the first dose or first few doses. A similar effect may occur if therapy is interrupted for more than a few doses. Syncope has been reported with other alpha-adrenergic blocking agents in association with rapid dosage increases or introduction of another antihypertensive drug. Syncope may be due to an excessive postural hypotensive effect, although occasionally the syncopal episode has been preceded by severe supraventricular tachycardia with heart rates of 120-160 bpm.

To decrease the likelihood of syncope or excessive hypotension, always initiate treatment with a 1mg dose at bedtime. The 2mg and 5mg tablets are not indicated as initial therapy. Increase dosage slowly, and add additional antihypertensive agents with caution. Caution patients to avoid situations where injury could result if syncope occurs during initiation of therapy.

In early studies, where increasing single doses up to 7.5mg were given at 3 day intervals, tolerance to the first dose phenomenon did not necessarily develop and the "first dose" effect was observed at all doses. Syncopal episodes occurred in 3 of 14 subjects given doses of 2.5, 5, and 7.5mg, which are higher than the recommended initial dose. Severe orthostatic hypotension (BP 50/0mmHg) was seen in two others and dizziness, tachycardia, and lightheadedness occurred in most subjects. These adverse effects all occurred within 90 min. of dosing.

In multiple dose clinical trials involving nearly 2000 patients, syncope was reported in about 1% of patients, in no case severe or prolonged, and was not necessarily associated with early doses.

If syncope occurs, place patient in recumbent position and treat supportively. There is evidence that the orthostatic effect of terazosin is greater, even in chronic use, shortly after dosing.

PRECAUTIONS: *General:* ***Orthostatic Hypotension:*** While syncope is the most severe orthostatic effect of terazosin, other symptoms of lowered BP, such as dizziness, lightheadedness and palpitations, are more common, occurring in 28% of patients in clinical trials. Patients with occupations in which such events represent potential problems should be treated with particular caution.

Information for Patients: Make aware of possibility of syncopal and orthostatic symptoms, especially at initiation of therapy, and to avoid driving or hazardous tasks for 12 hrs. after the first dose, after a dosage increase, and after interruption of therapy when treatment is resumed. Caution to avoid situations where injury could result should syncope occur during initial therapy. Advise to sit or lie down when symptoms of lowered BP occur and to rise carefully from a sitting or lying position. Bothersome dizziness, lightheadedness, or palpitations should be reported to physician.

Tell patients that drowsiness or somnolence can occur, requiring caution in people who must drive or operate heavy machinery

Laboratory Tests: Small but statistically significant decreases in hematocrit, hemoglobin, WBC, total protein and albumin were observed in clinical trials. The magnitude of decreases did not worsen with time. These findings suggest the possibility of hemodilution.

Drug Interactions: In controlled trials, terazosin was added to diuretics, and several beta-adrenergic blockers; no unexpected interactions were observed. Terazosin has also been used concomitantly without interaction in at least 50 patients on the following: 1) analgesic/anti-inflammatory (acetaminophen, aspirin, codeine, ibuprofen, indomethacin); 2) antibiotics (erythromycin, trimethoprim and sulfamethoxazole); 3) anticholinergic/sympathomimetics (phenylephrine HCl, phenylpropanolamine HCl, pseudoephedrine HCl); 4) antigout (allopurinol); 5) antihistamines (chlorpheniramine); 6) cardiovascular agents (atenolol, hydrochlorothiazide, methyclothiazide, propranolol); 7) corticosteroids; 8) gastrointestinal agents (antacids); 9) hypoglycemics; 10) sedatives and tranquilizers (diazepam).

Carcinogenesis, Mutagenesis, Impairment of Fertility: HYTRIN was devoid of mutagenic potential when evaluated *in vivo* and *in vitro*.

HYTRIN, administered in feed to rats at doses of 8, 40, and 250mg/kg/day for 2 yrs., was associated with a statistically significant increase in benign adrenal medullary tumors of male rats exposed to the 250mg/kg dose. This dose is 695 X max. recommended human dose (20mg/55kg). Female rats were unaffected. HYTRIN was not oncogenic in mice when administered in feed for 21 yrs. at a maximum tolerated dose of 32mg/kg/day.

The absence of mutagenicity in a battery of tests, of tumorigenicity of any cell type in the mouse carcinogenicity assay, of increased total tumor incidence in either species, and of proliferative adrenal lesions in female rats, suggests a male rat species-specific event. Numerous other diverse pharmaceutical and chemical compounds have been associated with these tumors in male rats without supporting evidence for carcinogenicity in man

Effects on fertility were assessed in a standard fertility/reproductive performance study in which male and female rats were administered oral doses of 8, 30 and 120mg/kg/day. Four of 20 male rats given 30mg/kg and 5 of 19 male rats given 120mg/kg failed to sire a litter. Testicular weights and morphology were unaffected. Vaginal smears at 30 and 120mg/kg/day appeared to contain less sperm than smears from control matings and good correlation was reported between sperm count and subsequent pregnancy.

Oral use for 1 or 2 yrs. elicited a statistically significant increase in testicular atrophy in rats exposed to 40 and 250mg/kg/day, but not in rats exposed to 8mg/kg/day (> 20 X max. recommended human dose). Testicular atrophy was observed in dogs dosed with 300mg/kg/day (> 800 X max. recommended human dose) for 3 months but not after 1 yr. when dosed with 20mg/kg/day. This lesion has also been seen with Minipress®.

Pregnancy: Teratogenic effects: Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women and the safety of terazosin in pregnancy has not been established. HYTRIN is not recommended during pregnancy unless potential benefit justifies potential risk to mother and fetus.

Nonteratogenic effects: In a peri- and post-natal development study in rats, significantly more pups died in the group dosed with 120mg/kg/day (> 300 X max. recommended human dose) than in the control group during the 3-week post-partum period.

Nursing Mothers: It is not known whether terazosin is excreted in breast milk; therefore, exercise caution when administering terazosin to a nursing woman.

Pediatric Use: Safety and effectiveness have not been determined.

ADVERSE REACTIONS: The prevalence of adverse reactions has been ascertained from 14 placebo-controlled studies conducted primarily in the U.S. The studies involved once-a-day administration of terazosin as monotherapy or in combination with other antihypertensive agents, at doses ranging from 1 to 40mg. All adverse events reported during these studies were recorded as adverse reactions. Adverse events where the prevalence rate in the terazosin group was at least 5%, where the prevalence rate for the terazosin group was at least 2% and was greater than the prevalence rate for the placebo group, or where the reaction is of particular interest are summarized below. Only asthenia, blurred vision, dizziness, nasal congestion, nausea, peripheral edema, palpitations and somnolence were significantly ($p < 0.05$) more common in patients receiving terazosin than in patients receiving placebo. Other events include **[%TERAZOSIN-%PLACEBO]**: asthenia (11.3%-4.3%), back pain (2.4%-1.2%), blurred vision (1.6%-0%), depression (0.3%-0.2%), dizziness (19.3%-7.5%), dyspnea (3.1%-2.4%), edema (0.9%-0.6%), headache (16.2%-15.8%), impotence (1.2%-1.4%), libido decreased (0.6%-0.2%), nasal congestion (5.9%-3.4%), nausea (4.4%-1.4%), nervousness (2.3%-1.8%), pain-extremities (3.5%-3%), palpitations (4.3%-1.2%), paresthesia (2.9%-1.4%), peripheral edema (5.5%-2.4%), postural hypotension (1.3%-0.4%), sinusitis (2.6%-1.4%), somnolence (5.4%-2.6%), tachycardia (1.9%-1.2%), weight gain (0.5%-0.2%)

Adverse reactions were usually mild or moderate in intensity but sometimes were serious enough to interrupt treatment. Adverse reactions that were most bothersome as judged by being reported as reasons for discontinuation of therapy by at least 0.5% of the terazosin group and being reported more often than in the placebo group **[%TERAZOSIN-%PLACEBO]** are: asthenia (1.6%-0%), blurred vision (0.6%-0%), dizziness (3.1%-0.4%), dyspnea (0.9%-0.6%), headache (1.3%-1%), nasal congestion (0.6%-0%), nausea (0.8%-0%), palpitations (1.4%-0.2%), paresthesia (0.8%-0.2%), peripheral edema (0.6%-0%), postural hypotension (0.5%-0%), somnolence (0.6%-0.2%), syncope (0.5%-0.2%), tachycardia (0.6%-0%).

Additional adverse reactions have been reported, but these are not distinguishable from symptoms that might have occurred in the absence of exposure to terazosin. The following additional adverse reactions were reported by at least 1% of 1987 patients who received terazosin in clinical studies or during marketing experience: abdominal pain, abnormal vision, anxiety, arrhythmia, arthralgia, arthritis, bronchitis, chest pain, cold symptoms, conjunctivitis, constipation, diarrhea, dry mouth, dyspepsia, epistaxis, facial edema, fever, flatulence, flu symptoms, gout, increased cough, insomnia, joint disorder, myalgia, neck pain, pharyngitis, pruritus, rash, rhinitis, shoulder pain, sweating, tinnitus, urinary frequency, urinary tract infection, vasodilation, vomiting.

DOSAGE AND ADMINISTRATION: Dose and dose interval (12 or 24 hrs.) should be adjusted according to BP response

Initial Dose: 1mg at bedtime. Observe the initial dosing regimen strictly to minimize potential for severe hypotensive effects.

Subsequent Doses: Slowly increase dose to achieve desired BP response. Usual dose range is 1mg to 5mg once a day. Some patients may benefit from doses up to 20mg/day. Doses over 20mg do not appear to provide further BP effect. Doses over 40mg have not been studied. Monitor BP at the end of dosing interval to assure control is maintained. It may be helpful to measure BP 2-3 hrs. after dosing to see if maximum and minimum responses are similar, and to evaluate symptoms which can result from excessive hypotensive response. If response is substantially diminished at 24 hrs. consider an increased dose or b.i.d. regimen. **If administration is discontinued for several days or longer, reinstitute therapy using initial dosing regimen.** In clinical trials, except for the initial dose, the dose was given in the morning

Use With Other Drugs: Caution should be observed when terazosin is administered concomitantly with other antihypertensive agents (e.g., calcium antagonists) to avoid the possibility of significant hypotension. When adding a diuretic or other antihypertensive agent, dosage reduction and retitration may be necessary.

August, 1987 **Abbott Health Care Products, Inc.** North Chicago, IL 60064 7083834

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DOCTOR'S NEWS

EXCHANGE ANNUAL MEETING APRIL 20

The Illinois State Medical Inter-Insurance Exchange will hold its annual meeting on Wednesday, April 20, 1988 at 4:00 p.m. at the Westin O'Hare. At that time, members of the Exchange's Board of Governors will be elected. Members of the Board shall be elected by a majority vote of the members represented at the annual meeting in person or by proxy.

The Board of Governors has general supervision over the finances of the Exchange and of its operations and establishes all policies governing the proper transaction and conduct of the business and affairs of the Exchange.

Any member of the Exchange interested in serving as a governor should so notify, *in writing*, Fred Z. White, M.D., chairman, Board of Governors, Illinois State Medical Inter-Insurance Exchange, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. Please include a current curriculum vitae. All letters of intent received at the Exchange office on or before February 4, 1988, will be considered by the nominating committee.

PHYSICIANS IN THE NEWS

The American Association of Gynecologic Laparoscopists at its 16th annual meeting last month elected two Chicago area physicians to serve as 1988 officers. **Donald L. Chatman, M.D.,** elected president, is affiliated with Michael Reese Hospital and Medical Center, Chicago, and the University of Chicago. **Raphael F. Valle, M.D.,** elected secretary-treasurer, is affiliated with Northwestern Memorial Hospital, Chicago . . . **Rowine Hayes Brown, M.D., J.D.,** was recently awarded the 1987 Mary Harris Thompson M.D. Foundation Award by Mary Thompson Hospital, Chicago.

Isaac Martin Thapedi, M.D., Chicago, was elected president of the medical staff of Saint Bernard Hospital, Chicago, and was appointed to its Board of Trustees . . . **Benjamin T. Williams, M.D.,** was named head of the department of pathology at the University of Illinois at Chicago. He has been associated with the University since 1973 . . . **Lillian Widmer,** Wheaton, will retire December 31 after 27 years as executive administrator of the DuPage County Medical Society. ◀



Here Today. Here Tomorrow.

Today, most commercial professional liability insurers have abandoned the Illinois market. But there's still one company writing malpractice coverage up to $2 million per incident with a $4 million aggregate—the Illinois State Medical Inter-Insurance Exchange.

The Exchange is the only malpractice insurer in Illinois that is owned and operated by physicians. As such, we are totally committed to meeting the insurance needs of our policyholders. And we intend to be there as long as they need us.

Despite the recent explosion in medical malpractice litigation, the Exchange remains in good shape financially. Much of our success can be attributed to the willingness of the company's physician directors to make tough decisions—decisions like the switch to a "claims-made" policy form...the setting of adequate premium levels...and the strengthening of standards for renewing coverage and accepting new policyholders.

In the continually changing liability climate, the Exchange's directors will continue to make the sound business decisions necessary to ensure the company's long-term financial stability. But as physicians themselves, they also will be making those decisions from a policyholder's perspective. And that will translate into the best possible insurance coverage available, including...

...aggressive defense of frivolous claims;

...policyholder participation in any decision to settle a claim or suit;

...peer review of an adverse underwriting or claim decision;

...help for policyholders in avoiding the situations that can lead to suits; and

...premium rates that fairly reflect the risks inherent to the physician's own practice.

As a company owned and operated by physicians, the Exchange exists solely for the benefit of its policyholders. Some 9,000 physicians in Illinois are depending upon us. And we don't intend to let them down.

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Editorial Board Members Commended

The September issue of IMJ *featured an editorial commending retiring Editorial Board Chairman J. William Roddick, Jr., M.D., for service to the Society. At this time, we introduce the members of the* IMJ *Editorial Board. Their contributions have greatly enhanced the quality of* IMJ *content.*

David E. Trachtenbarg, M.D., a family practitioner, is associate director, department of family practice at the Methodist Medical Center and the University of Illinois College of Medicine at Peoria. Dr. Trachtenbarg is acting as interim chairman of the Editorial Board pending results of an ongoing communications study which will determine future directions of the *Journal.*

Larry C. Gunn, M.D., a board certified surgeon, is clinical assistant professor of surgery, University of Illinois, Chicago. Dr. Gunn, who maintains a private practice in Hinsdale, is affiliated with Hinsdale Hospital and Good Samaritan Hospital, Downers Grove.

Eugene J. Rogers, M.D., specializes in physical medicine and rehabilitation and is affiliated with the University of Health Sciences/ Chicago Medical School, Chicago, as professor and chairman of the department of rehabilitative medicine.

Constantine S. Soter, M.D., F.A.C.R., specializes in radiology and is affiliated with the department of radiology and nuclear medicine at Northwest Community Hospital, Arlington Heights.

Donald D. Van Fossan, Ph.D., M.D., is chairman, department of pathology, at St. John's Hospital, Springfield, and clinical professor of pathology at the Southern Illinois University School of Medicine, Springfield.

Edward A. Wolpert, M.D., a psychiatrist, is director of the Psychosomatic and Psychiatric Institute and clinical professor of psychiatry at the Pritzker School of Medicine, University of Chicago.

The following list includes physicians who served on the *IMJ* Editorial Board in the years following its inception in 1978, but who are not currently members.

Eli L. Borkon, M.D., Ph.D., F.A.C.P., is professor emeritus of Southern Illinois University School of Medicine. Dr. Borkon, a nuclear medicine specialist, is associate dean of the SIU School of Medicine and past governor of the American College of Physicians.

Joseph R. Christian, M.D., Chicago, is professor emeritus and past chairman of pediatrics, Rush Medical College, Chicago.

Daniel G. Cunningham, M.D., Chicago, is program director, department of pediatrics, at Mercy Hospital and Medical Center, Chicago. He is affiliated with the department of pediatrics at Loyola University Stritch School of Medicine, Maywood.

Raymond A. Dieter, Jr., M.D., a board certified thoracic surgeon, is clinical assistant professor at Loyola University Stritch School of Medicine, Maywood. Dr. Dieter is affiliated with Central DuPage Hospital, Winfield, Good Samaritan Hospital, Downers Grove, and Memorial Hospital of DuPage County, Elmhurst.

James Ekeberg, M.D., Palatine, a board certified family practitioner in private practice, is affiliated with Northwest Community Hospital, Arlington Heights.

Ediz Z. Ezdinli, M.D., who died June 7, 1987, was a professor of medicine at the University of Health Sciences/The Chicago Medical School. He was chief of the division of hematology/ oncology there, and also at the VA Medical Center, North Chicago. Dr. Ezdinli was affiliated with St. Mary of Nazareth Hospital Center, Chicago.

Carl F. Neuhoff, M.D., who died in July of 1986, specialized in family practice and was affiliated with St. Francis Hospital, Peoria, where he was president of the medical staff, chairman of the family practice department and founder of their mobile outreach clinics. He also was a clinical assistant professor at the University of Illinois College of Medicine at Peoria.

In addition to our regular reviewers, IMJ *has had the benefit of subspecialty reviewers over the years. We wish to thank the following physicians for their contributions:*

Ashok Agarwal, M.D.	Internal Medicine	Carbondale
Allan Bennett, M.D.	OB/GYN	Carbondale
Paul A. Bennett, M.D.	Family Practice	Carbondale
Paul Blumenthal, M.D.	OB/GYN	Chicago
Sheffield Boardman, Jr., M.D.	Internal Medicine	Carbondale
James Cavanaugh, Jr., M.D.	Forensic Psychiatry	Chicago
James R. Couch, Jr., M.D.	Neurology	Springfield
Donald R. Darling, M.D.	Internal Medicine	Carbondale
Bhogaraju S. Devi, M.D.	Therapeutic Radiology	Schaumburg
J. Kevin Dorsey, M.D.	Internal Medicine	Carbondale
Sherman C. Feinstein, M.D.	Child Psychiatry	Highland Park
Phillip G. Galle, M.D.	OB/GYN	Springfield
Robert S. Grover, M.D.	Clinical Pathology	Springfield
Ahmad Hamidinia, M.D.	Urological Surgery	Springfield
William R. Hamilton, M.D.	Pediatrics	Carbondale
Robert C. Kaufmann, M.D.	OB/GYN	Springfield
Fazlur Khan, M.D.	Therapeutic Radiology	Oak Brook
Omer Kucuk, M.D.	Oncology	Chicago
Sadasivam Modali, M.D.	Neurology	Carbondale
Victoria R. Nichols, M.D.	OB/GYN	Springfield
William M. Nickey, M.D.	Pathology	Springfield
Emmet F. Pearson, M.D.	Internal Medicine	Springfield
Lawrence Perlman, M.D.	Internal Medicine	Chicago
Sergio Rabinovich, M.D.	Internal Medicine	Springfield
David Rendleman, M.D.	General Surgery	Carbondale
Michael F. Shekleton, M.D.	Gastroenterology	Peoria
Howard R. Terebelo, D.O.	Hematology	West Bloomfield, Michigan
Antoinette G. Thomas, M.D.	Clinical Pathology	Carbondale
Howard S. Traisman	Pediatrics	Evanston
Michael Zindrick	Orthopedic Surgery	Hinsdale

Moratorium on Acceptance of Manuscripts for Review

The ISMS Board of Trustees has agreed to a moratorium on acceptance of manuscripts for *IMJ* editorial review. This action was taken at the November 6 Board of Trustees meeting.

The ISMS Publications Committee recommended this action out of a concern for the manuscript backlog in the context of an ongoing ISMS communications study. The duration of the moratorium will be determined by the ISMS Publications Committee at some time after the Board reviews and acts on final recommendations engendered by the communications study.

History of the Study

In January, 1987, each ISMS member received a survey on issues related to the Society's activities. The results of that survey have guided the Board in directing the energies and resources of the leadership and staff.

One section of the survey focused on the *Illinois Medical Journal.* A clear majority—59% of respondents—indicated that they would prefer a socioeconomic focus for the Society's flagship publication. This survey was followed by a series of focus groups of physicians across the state, who reinforced and expanded upon the interest in socioeconomic features.

The final results of the communications study will be before the Board of Trustees for action early in 1988. After the Board examines recommendations and determines what changes are to be made in the Society's communications program, the Publications Committee will be able to make a final decision on the appropriateness of clinical content.

New manuscripts will not be accepted for review by the *IMJ* Editorial Board after December 31, 1987.

The Experience of a Lifetime

By Roderick L. Matticks, Delegate, SIU School of Medicine, Springfield

It is a rare yet curious opportunity to hear about the experiences and feelings a physician faces when affected by major illness or surgery. Martha Weinman Lear's account of the dilemmas that she and her physician husband endured during a long and trying illness is beautifully depicted in her book *Heart Sounds: The Story of Love and Loss.* It is rarer still when we can personally experience an opportunity to gain new insights into what our patients must endure when faced with the need for major surgery. I was "blessed" with this privilege during the summer between my third and fourth year of medical school. At that time it was decided to replace my badly insufficient aortic valve. A routine procedure, of course, until it happened to *me*! This operation certainly provided an insight into the hospitalization process that I would have never gotten during rotations and electives.

The role that nursing and ancillary health services play is one which I had underestimated, despite my previous employment in the profession. I received vital, compassionate care from these people. Their presence induced a soothing atmosphere and I always felt watched over and protected. It's easy for us to lose perspective on what these people do and how hard they work for patients.

Patients look forward with anticipation to those few minutes they spend daily with their physician. This is the big moment. It seems virtually impossible to address all of the questions and concerns during that brief visit with the doctor. It wasn't easy to remember all I wanted to cover. I have learned to ask my patients to try and write down their questions and use the list to recall their concerns when I visit. Also, it is important to question patients as to their reactions to the medications they are taking. For example, I began having anticholinergic side effects from a particular pain medication. Of course, I had the advantage of knowing, despite my patient status, why I was having those unusual feelings. However, it is difficult to determine whether the effects were surgery or medication related. Patients should be judiciously quizzed about possible side effects as well as other concerns they may be having. Ask them how well they are satisfied with the quality of service they are receiving. After all, this is a very expensive service they are purchasing and they deserve to be satisfied with the product.

If you have ever had second (or third) thoughts about eating in a hospital cafeteria because of unappetizing food, don't be alarmed by the lack of appetite of a recovering or ill patient. It takes quite an imagination to turn some hospital food into an edible delicacy, especially when you do not feel well and have had several medications which do not help in tempting the palate. I lost several pounds as a result, but was fortunate to have had someone who understood and brought in something I could eat. I feel it would be prudent to encourage those responsible for preparing hospital food to strive for consistent palatability of patient meals.

The most alarming feelings associated with major surgery affect the psyche. These are major stresses

that affect the patient and the patient's family. Even though we may assume that families are kept well informed about the patient's progress, especially during and immediately following surgery, we must monitor how those concerned are tolerating and understanding the information they receive. Families need a great deal of support and encouragement during this trying time. It is important that their needs are satisfied. Reactions to stress, which may not be readily apparent to us, can have an effect on the patient's recovery. It took several weeks to work through my family's reactions to the great stress of the day.

Fortunately, I only spent six days in the hospital. I didn't think I could take more! Still, I felt nervous about leaving the security of a continuously-monitored environment. It is difficult to convince yourself that you can make it on your own. In addition, most of the hospital stay is spent under the influence of various drugs. When I came home and the drugs were wearing off, it was difficult at times to figure out what was real and what was not. This was very frightening! Add to that the aches and pains, the reality of having had open heart surgery and family problems resulting from their experiences, and the results are really alarming!

If it weren't for the love, support and patience I received in the hospital and at home from my girlfriend, my recovery would certainly have been prolonged. Of course, it helps that she is a nurse. It makes a big difference when someone experienced assists with the medications, daily activities, and exercise. The subsequent resolution of the family problem was a big relief, too. And, of course, the medical staff was supremely kind and helpful!

No doubt, cardiac surgery is a major undertaking, one which physicians may tend to underestimate in the routine of things. It certainly proved to be educational to be on the receiving end. Now, if I can only convince the Dean to authorize credit for an elective in cardiac surgery! ◀

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Reviews do not constitute legal advice. They provide a working document which highlights key issues, such as malpractice coverage, reimbursement concerns and practice limitations.

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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Authorization Denied

PAYMENT REFUSED

New cost containment mechanisms go hand-in-hand with the new economic structures of alternative delivery systems. HMOs, PPOs and IPAs attempt to control costs by requiring the treating physician to obtain approval before care is rendered. This system of utilization review is generally called prior authorization. Some believe the potential for harm is inherent in the system, while others view the system as the best and only way to contain costs. Regardless of the controversy about the effects of prior authorization, one thing is certain: Prior authorization creates new responsibilities for the physician as the patient's advocate.

Because the system often hinges on the physician's contractual obligation to abide by the HMO, PPO or IPA utilization review process and ties economic incentives with compliance, one might think that a good starting point to understand the physician's new responsibilities would be to examine the contract. The contract, however, is frequently the source of the physician's confusion.

Contracts generally require the physician to render "medically necessary" covered services and to obtain prior authorization before certain services are rendered. If the HMO, PPO or IPA (review organization) determines that the service is "medically necessary," authorization is granted, otherwise, it is denied. The term "medically necessary" can confuse the treating physician, especially when authorization is denied and the denial is based on the judgment of a board certified physician employed by the HMO, PPO or IPA. Although the contract does establish an economic and legal relationship between the treating physician and the HMO, PPO or IPA, the ethical and legal responsibility for the exercise of good medical judgment remains with the treating physician. It does not shift to the review organization. Equally important, the physician's "standard of care" is not diminished under such cost containment programs as prior authorization.

One way to understand the physician's responsibilities as the patient advocate under prior authorization systems is to examine the conventional system. Traditionally, utilization review took place *after* care was rendered by examining the patient's chart to determine if the treatment provided was medically necessary. If the third party payor's reviewer found the treatment not medically necessary, the patient's claim for payment was denied. But under prior authorization, the payment question may become inseparable from the question of what care the patient actually receives. The treating physician's judgment regarding the patient's course of treatment is evaluated by the reviewer before care is rendered.

In the Wickline Case (California Court of Appeals) the court recognized that the cost containment strategy of prior authorization places new and added pressures on quality assurance. The court stated that an erroneous medical necessity decision by the review organization under the prior authorization system, in practical terms, may result in the withholding of necessary care. This has the potential to lead to a patient's permanent disability or death. As one commentator succinctly noted: "Denial of claims is measured in dollars; denial of care in lives."

The added pressures on quality assurance inherent in prior authori-

zation flow directly to the physician. Medical care decisions are grounded on the treating physician's personal knowledge of the patient's condition in addition to the patient's informed consent. The fact that a contract obligates the physician to comply with utilization review decisions and penalizes those who do not, by contract termination or financial sanctions, does not alter the physician's primary obligation to his or her patients. When a utilization review organization second guesses the treating physician's medical judgment, the responsibility for the medical decision does not shift to the organization, it remains with the physician.

In the Wickline Case the court stated:

> "The physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour."

In practical terms the refusal to authorize treatment generally means that the entity refuses to pay for it. To some it may appear that the system puts the physician between the proverbial rock and a hard place. But there are several actions physicians can and should take to protect their patients and themselves when the review organization denies authorization for recommended treatment. When this happens the informed physician follows two commandments: Protest and Document.

As one would imagine, prior authorization review procedures vary greatly. For a national network PPO, you may begin the process by calling an 800-number and speaking to a reviewer hundreds of miles away. If you belong to a local IPA the reviewers and their procedures may be familiar to you. Most review programs have more than one level of review enabling you to appeal a decision which denies authorization for care you have recommended. Using all available procedures, the informed physician vigorously protests denials. If the denial stands at the second level of review and a third level exists to protest the denial, the informed physician uses it. Generally speaking, follow all procedures stated in the contract and exhaust all options available under the contract.

As each protest is lodged, the informed physician documents the dispute and the steps taken to resolve it. The patient is informed of the physician's recommendation and of the risks involved if that recommendation is not followed. The physician also tells the patient that the plan is against the recommended treatment and that the patient may be liable for payment if treatment is received without plan authorization. This information is noted in the patient's chart and in letters sent to both the review organization and the patient.

Because you're an informed physician, who recognizes the complex issues involved in contracts for the delivery of medical care, your first step was to send the contract offered you or your IPA to the ISMS Office of Contractual Services. If you're an ISMS member, the office will provide you objective comments on any HMO, PPO or IPA contract for the nominal fee of $100.00 per review. Contract reviews highlight the most important contract provisions, in addition to those which may need further clarification or investigation.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for a careful review and reading of the contract itself. It's not legal advice, and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀



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Barnes, Gareth B., Elgin, died September 28, 1987 at the age of 71. Dr. Barnes was a 1941 graduate of Duke University School of Medicine, Durham, North Carolina.

***Griffin, William D.,** Peoria, died September 4, 1987 at the age of 71. Dr. Griffin was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

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***Laprus, Steven Z.,** Elmwood Park, died May 20, 1987 at the age of 73. Dr. Laprus was a 1940 graduate of the Akademia Medyczna Wydzial Lekarski, Warszawa, Poland.

****Lustgarten, Earl M.,** Scottsdale, died October 12, 1987 at the age of 84. Dr. Lustgarten was a 1931 graduate of the University of Illinois College of Medicine, Chicago.

****Murphy, Edward S.,** Dixon, died September 14, 1987 at the age of 77. Dr. Murphy was a 1936 graduate of Rush Medical College, Chicago.

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Rogers, J.C. Thomas, Livingston, Texas, died October 3, 1987 at the age of 87. Dr. Rogers was a 1926 graduate of Rush Medical College, Chicago.

***Schroeder, Orlando,** Chicago, died October 11, 1987 at the age of 59. Dr. Schroeder was a 1953 graduate of the Facultad de Medicina de la Universidad de Nuevo Leon, Monterrey, Nuevo Leon, Mexico.

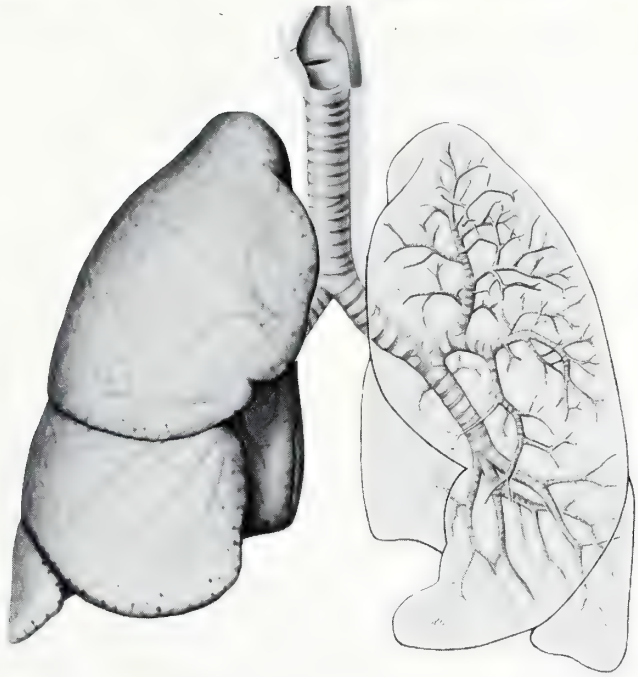
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A Rare Disorder

Primary Esthesioneuroblastoma of the Orbit

By Wagih M. Shehata, M.D., F.F.R./Cincinnati, Ohio

Esthesioneuroblastoma is an uncommon, malignant tumor of neural crest origin which commonly arises from the olfactory epithelium in the nasal cavity, nasopharynx or paranasal sinuses.[1-3] It rarely presents as an intracranial tumor, which is histologically and ultrastructurally similar to the more common childhood neuroblastoma of the brain and the rare adult neuroblastoma of the sympathetic nervous system.[4]

Neuroblastomas tend to metastasize to the orbit later on during the course of the disease.[5] However, primary neuroblastoma of the orbit, to the best of our knowledge, has not been described in the literature prior to this writing.

The following reports a case of esthesioneuroblastoma which seems to have originated from the optic nerve or the posterior part of the orbit, and was successfully treated by radical surgery and radiation.

A 30-year-old white married male presented with a three-month history of loss of the peripheral field of vision in the left eye, erythema of the medial conjunctiva and mild proptosis of the same eye. There was no pain, fever, weight loss or other symptoms. Past and family histories were basically unremarkable. On examination, his general condition was excellent and there was no palpable lymphadenopathy. Proptosis and redness of the medial sclera of the left eye was noticed. Pupils were equal and reactive to light. The extra-ocular movement of the left eye was limited laterally. Funduscopic and the remainder of the examination was unremarkable. Routine chest x-ray and liver enzymes were within normal limits. CT scan of the brain and orbits showed an egg-shaped, homogeneous mass within the medial aspect of the left orbit. The mass measured $3 \times 2.3 \times 2$cm in diameter pushing the left eye anteriorly and laterally. The left optic nerve appeared to be stretched over the lateral surface of the mass. There was no evidence of intracranial extension and both optic foramina were normal in appearance.

The left orbit was explored via a left lateral Kronlein's orbitotomy incision. The mass was found to be medial and superior to the optic nerve. It was seemingly adherent to the optic nerve, with the appearance of a hemangioma. The tumor, however, was extremely adherent to the surrounding tissue. During dissection, the capsule of the tumor was ripped and the contents of the tumor exuded from the mass. On frozen section examination, there was a solid small cell malignant tumor. The mass was excised with probable residual disease left behind.

Histological examination revealed infiltrative cords of malignant small round cells attenuated by fibrillar areas of eosinophilic materials resembling glial tissues. The cells had hyperchromatic nuclei with coarse chromatin. Some had indistinct cytoplasm and others had cytoplasm of columnar configuration. The tumor cells were focally arranged in rosette-like formations. Electron microscopic studies showed the tumor to be consistent of a fairly-uniform population of small cells. The nuclei are round with only slight irregularity. There was an equal mixture of hetero- and euchromatin. Nucleoli were small and inconspicuous. Numerous electron-dense granules were present in most of the cells. Scattered mitochondria and RER (rough endoplasmic reticulum) were seen. Cytoplasmic filaments (neurofilaments) were present. Cytoplasmic cell processes were not seen. Both the light and electron microscopic pictures were found to be consistent with a

diagnosis of neuroblastoma. (Figure 1)

Subsequent extensive work-up including bone and liver scans, catecholamine determination, iliac bone marrow aspiration biopsy, paranasal sinus x-rays, intravenous pyelogram, CT scan of the chest and abdomen and CEA showed no evidence of abnormality or metastatic disease. The patient was examined by an ear, nose and throat specialist who found no evidence of primary disease in the nasal cavities or sinuses.

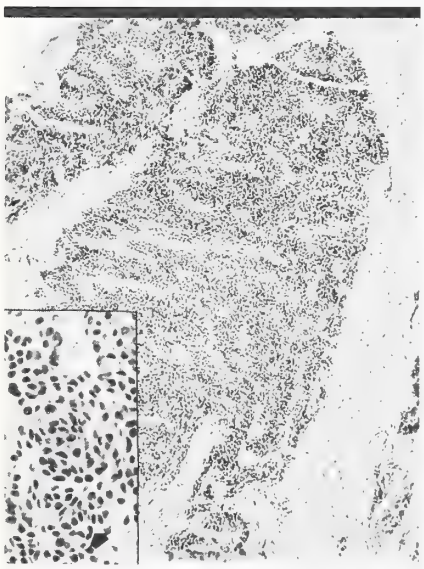


Figure 1
A low power view and insert for high power, showing rosette formation of the tumor under light microscopy.

Four weeks after the resection of the mass, the patient underwent left orbital exenteration with removal of the lateral bony wall of the left orbit. Subsequent histological examination revealed residual neuroblastoma tissue involving the posterior orbital contents which was not directly involving the left optic nerve. The patient was seen by a medical oncologist and was not started on chemotherapy. Because of an initial rupture of the tumor capsule and the presence of residual disease at the posterior orbital wall, the patient was referred to us for postoperative irradiation. Subsequent CT scan of the brain showed no intracranial extension and the ethmoid sinus area was unremarkable.

The patient received 4600 rad (cGy) by 23 treatments (200 rad/day) over 34 days, utilizing direct anterior 6 × 6cm field by the 16 MeV electron beam. The field was angled 20° laterally to coincide with the curvature of the left orbit. The patient was treated with a special custom tissue density material as a bolus, filling the inside of the left orbit to ensure homogeneous dose distribution. He tolerated the treatment fairly well with mild skin erythema and mild, moist desquamation of the surface cavity of the left orbit. The patient was fitted for a left orbital eye prosthesis. He remains alive and well, free of disease three years after the diagnosis.

Discussion

Berger, in 1924,[6,1] reported the first two cases of esthesioneuroblastoma, while Schall and Lineback in 1951 reported the first case in the American literature.[1] As of 1980, there were 300 reported cases.[1] These tumors commonly arise from the nasal cavity, from the mucosa close to the cribriform plates representing 1%-5% of nasal tumors.[1,7] Unilateral nasal obstruction, loss of smell, epistaxis and headaches are among the common presenting symptoms. There is male predilaction,[6,1] it is rare in blacks[7] and has two peak age distributions[1,7] (second and fifth decades). These tumors tend to have a long natural history[7] and rarely metastasize to regional nodes.[6] Occasionally, it spreads along the cerebral spinal pathway[4] or results in extra-neural metastasis to lungs. Our reported case represents a rare site of tumor presentation which could have originated from the optic nerve or possibly the posterior orbital wall. Our patient did not have any tumor involvement in the nasal cavity or paranasal sinuses.

These tumors contain neurosecretory granules and might produce catecholamines.[1] On histological examination, such tumors could be easily misdiagnosed with other tumors such as anaplastic tumors, immature teratoma, schwannosarcoma, plasmocytoma, rhabdomyosarcoma, reticulum cell sarcoma, malignant melanoma, Ewing's sarcoma and transitional cell carcinoma.[1,2,7] It is characterized by round oval, slightly-fusiform cells which are the size of lymphocytes.[1] Pseudorosette formation, true neurofibrilles, perivascular palisading, increased microvascularity and interstitial calcifications are common histological features associated with these tumors.[1] Appearance is similar to ganglioneuroblastoma. Electromicroscopic features are most helpful in establishing the final diagnosis.[1,2,7] Olfactory esthesioneuroepithelioma, olfactory esthesioneurocytoma and olfactory esthesioneuroblastoma are among the three main histological types described in the literature.[6,1] These probably have no effect on the prognosis of this disease. Prognosis is mainly determined by the stage described by Kadish, *et al.*,[7,8] with stage A being confined to the nasal cavity, stage B being extension to one or more paranasal sinuses, and stage C involving the orbit, skull, intracranial cavity, cervical lymph nodes or distant metastases. Five-year survival is in the range of 70% for stages A and B, with a poor prognosis for stage C.[1] Local recurrence rate is relatively high (68%)[1] after surgery alone, which is usually not complete due to the difficulty in totally excising these tumors and the possible intracranial extensions.[1,6] Postoperative irradiation is usually recommended and seems to be effective for doses in the range of 5000-6000 rad.[1] There is no need for prophylactic neck irradiation.[1] These tumors are radiosensitive, therefore, radical surgery is not essential. Adequate doses of radiation could be delivered following just a biopsy.[6]

This approach could have been utilized in an attempt to save the vision of the left eye and avoid disfigurement. On the other hand, retinal degenerations and cataract formation can occur in a significant percent of patients after doses in the range of 6000 rad, making it difficult to maintain a useful eye. However, with the availability of CT

scan and modern precision radiotherapy, the morbidity to the eye could be minimized.

Chemotherapy is rarely utilized, usually only for stage C patients, with some success.[3] Cyclophosphamide, nitrogen mustard, vincristine, thiotepa, doxorubicin and DTIC are among the useful chemotherapeutic agents.[9]

In conclusion, we presented a rare case of primary esthesioneuroblastoma of the orbit which was successfully treated by radical surgery and radiation. The patient remains free of disease after three years.

Acknowledgement

The authors acknowledge the efforts of Kenneth Clark, M.D., Thomas Panke, M.D., and Deborah Carr.

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PRACTICAL • CLINICAL • EDUCATIONAL • CURRENT

Tuberculous Mastoiditis Presenting with Tuberculous Meningitis

By Eugene P. Podrazik, M.D., Michael A. Mikhael, M.D., Ph.D., and Allan P. Wolff, M.D./Evanston

A 42-year-old Haitian female was admitted to our institution because of severe right mastoid pain and debilitating headaches. Her admitting chest film revealed evidence of miliary tuberculosis. Systemic spread of tuberculosis to the meninges and right mastoid was confirmed by culture. Appropriate anti-tuberculous chemotherapy resolved her illness and allowed mastoidectomy to be deferred.

Tuberculous mastoiditis is an extremely uncommon disease process and is rarely seen or reported in the modern Western world medical literature. However, the increased migration of Third World citizens to urban and rural America has caused the rate of pulmonary tuberculosis to increase in the United States. Concomitant increased occurrence of tuberculous mastoiditis similarly is to be expected.

Case Report

A 42-year-old Haitian female presented to our institution's emergency room complaining of severe right otologia, excruciating bitemporal headaches, lightheadedness and fever. Significant history included a six-week bout of persistent right otitis media, treated for five weeks by oral penicillin G, followed by one week of trimethoprim/sulfamethoxazole.

Physical examination revealed a lethargic woman holding her right ear. She was in obvious pain. Her right tympanic membrane was chalky white and thickened. She had no other significant findings. There were no meningeal signs and her left ear was normal.

Admission chest x-ray revealed a reticular infiltrate throughout both lung fields. (Figure 1) A lumbar puncture revealed 70 white cells per cubic millimeter, a protein of 26mg/dl and a glucose of 116mg/dl. Gram stains and AFB smears failed to reveal tuberculosis bacilli. A CAT scan of the head revealed sclerosis of the right mastoid air cells. (Figure 2) An audiogram dem-

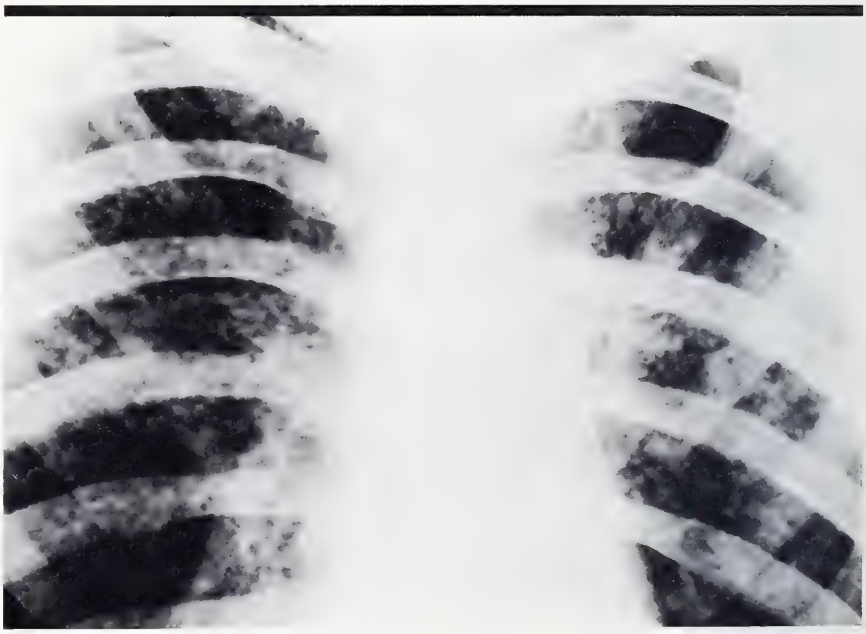


Figure 1
Chest x-ray with reticular infiltrate characteristic of miliary tuberculosis.

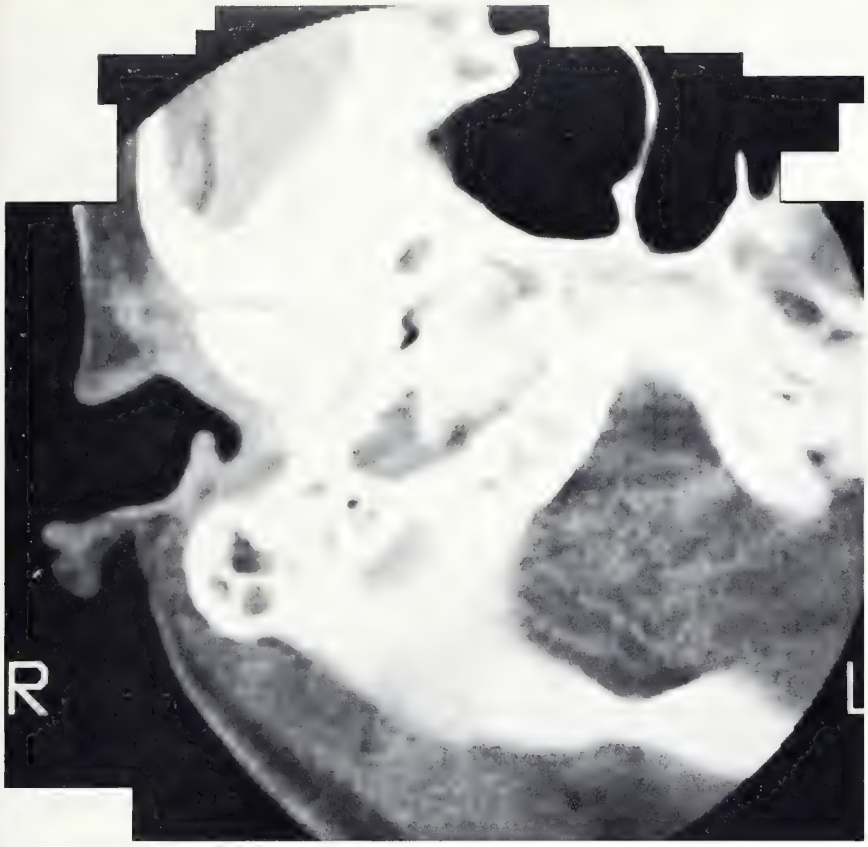


Figure 2
CAT scan of the head revealing sclerosis of the right mastoid air cells.

onstrated a conductive hearing loss in the right ear. A myringotomy was performed through a markedly-thickened tympanic membrane. One-half cubic centimeter of turgid fluid was obtained for culture.

A presumptive diagnosis of disseminated miliary tuberculosis was made on the basis of a positive chest x-ray, a spinal tap showing bacterial meningitis, and a history of prolonged otitis media with abnormal middle ear pathology. The patient responded rapidly to a triple course regimen of isoniazid, rifampin and ethambutol.

Subsequently, the clinical diagnosis was confirmed by positive cultures of tuberculosis from the sputum, middle ear aspirate and cerebrospinal fluid.

Discussion

Over the past 50 years, the evidence of pulmonary tuberculosis has decreased substantially. Likewise, concomitant occurrence of tuberculous mastoiditis has also diminished. Only sporadic and isolated case reports appear in the current literature.[1,2] This significant decline has been caused by the persistent vigilance of the American health care profession, better nutritional status of the citizenry, and development of potent anti-tubercular therapy.

However, the United States is seeing a dramatic increase in migration of persons from underdeveloped societies and Third World nations where pulmonary tuberculosis is still very endemic. These migrants are settling in both urban and rural America. More tuberculosis cases will be seen in our medical centers and, concomitantly, more tuberculous mastoiditis.

Tuberculous mastoiditis is to be suspected in any Third World migrant who has a persistent otitis media unresponsive to prolonged antibiotic therapy. The tympanic membrane may be chalky white and thickened and may contain multiple dry perforations, or it may be draining a foul, purulent exudate. There may be persistent pain, or the whole process may be painless. Destruction of the ossicles will lead to a conductive hearing loss. Facial nerve paralysis and mastoid-cutaneous fistulas have been reported.[2-7]

Tuberculous mastoiditis is usually secondary to systemic spread from a pulmonary focus. Other bone sites may also be involved. Powerful specific antibiotics are now available to eradicate tuberculosis, and mastoid surgery can usually be avoided. ◀

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How Safe Is It?

High Dose Intravenous Methylprednisolone

By Ruth Ditzian-Kadanoff, Ph.D., M.D., and Michael H. Ellman, M.D./Chicago

Intravenous pulse methylprednisolone can be life saving, but serious side effects from this treatment may occur. Rapid intravenous push of the medication may precipitate a drop in systemic vascular resistance and in blood pressure, and sudden death has been reported. This method of rapid administration should be avoided. Infrequent but serious anaphylactoid or anaphylactic reactions to intravenous methylprednisolone also may occur. These reactions are likely triggered by the methylprednisolone salts rather than the base corticosteroid. Occult infections may disseminate and should be carefully excluded before intravenous methylprednisolone use. Avascular necrosis is likely to occur in five percent of patients.

High dose (usually 1000mg) pulse intravenous methylprednisolone (IVMP) is frequently used for treatment of many diseases including transplant rejections,[1] multiple sclerosis,[2] myasthenia gravis,[3] and autoimmune disorders such as systemic lupus erythematosus, polymyositis, rheumatoid arthritis, and mixed connective tissue disease.[4] Moderate doses of IVMP are often administered in emergency rooms for treatment of acute asthma. Frequently, IVMP is administered in ambulatory settings. The benefits of IVMP therapy continue to be debated in the literature with few well-controlled studies. How safe is it?

Sudden death has been associated with IVMP. Thompson, *et al.*,[5] studied 365 patients receiving IVMP following kidney transplantations and any ensuing episodes of rejection. Two patients experienced sudden death. One patient had received the corticosteroid as a bolus administration, the other patient had received it over a 10-minute period. Autopsy results demonstrated frothy liquid in the bronchi and pulmonary edema in one of the patients. The other patient had hyperinflation of the lungs and high protein containing serous fluid with scant mucus in the bronchi. The authors subsequently studied six patients given IVMP over a 10-minute period. Blood pressure, cardiac rhythm and electrolytes were assessed prior to and one hour after the infusions. No changes were seen in the serum sodium, phosphate, and bicarbonate levels, but the mean potassium levels rose slightly from 4.63 ± 0.93 to 4.87 ± 0.85mEq/l (not statistically significant). No adverse reactions were seen in these patients.

Four cases of serious reactions to IVMP in renal transplant patients were reported by Stubbs, *et al.*,[6] with three of those patients experiencing fatal arrhythmias. Three men and one woman received IVMP in doses of 500 to 2000mg IV over periods ranging from 20 seconds to 20 minutes. The patients had bradycardias and bizarre QRS configurations. Complete atrioventricular block was noted in one patient and idioventricular rhythm in another. The patient who recovered experienced hypotension with blood pressure falling from 140/90 to 100/60mg/Hg. Electrocardiogram of this patient demonstrated transient changes suggestive of an acute myocardial infarction.

Nasswetter, *et al.*,[7] in 1974, monitored five patients with ankylosing spondylitis who were receiving three IVMP injections of 1gm each. The infusions were administered over 60 minutes on days one, four, and eight. The patients were monitored for 24 hours before and after each infusion. No arrhythmias were seen. There were also no changes in serum potassium or sodium. Glucose was elevated in all patients for 24 hours after the pulse therapy at a mean of 119mg/dl, but lowered to a normal mean of 82mg/dl in one day. A transient increase in urinary potassium excretion and a decrease in urinary sodium excretion were noted. The lack of cardiac side

effects to the IVMP was reassuring, because ankylosing spondylitis has been associated with cardiac conduction defects in as many as a third of patients.[8]

Anaphylactoid and anaphylactic reactions, some fatal, have also been documented. Freedman, *et al.*,[9] described an asthmatic who received 250mg of IVMP over one minute. After 30 seconds, acute bronchospasm developed with urticaria, hypotension, and sinus tachycardia. The patient required intubation. After recovery, positive skin tests to methylprednisolone hemisuccinate and to hydrocortisone succinate were found, but none were seen to the acetate salts of those steroids, nor to the diluents.

Peller, *et al.*,[10] described an anaphylactoid reaction in a patient. Within minutes of receiving 100mg of IV hydrocortisone, the patient developed sneezing, nasal congestion, hives, and periorbital angioedema, as well as a "thick tongue" and generalized pruritus. Hypotension or bronchospasm were not seen. The symptoms resolved in five hours. The patient did not respond with a wheal or flare to intradermal skin testing containing methylprednisone or hydrocortisone or the diluent.

Mendelson, *et al*,[11] reported anaphylaxis in an asthmatic patient. The patient developed a pruritic, urticarial rash, angioedema, and bronchospasm to methylprednisolone sodium succinate and hydrocortisone sodium succinate. Similar reactions occurred to rechallenge with intravenous methylprednisolone sodium succinate and an oral methylprednisolone tablet, but not to oral prednisone or prednisolone. Similar cases have been reported.[12-16] Two patients experienced anaphylaxis to intramuscular injections of 100 and 200mg respectively of hydrocortisone sodium succinate.[12,13] One of these two patients[12] demonstrated a positive intradermal reaction to the succinate, but not to hydrocortisone acetate or the diluent.

Palm, *et al.*,[17] experimented with dogs to determine if the speed of injection was important in causing side effects. IVMP of 30mg/kg was administered to 15 dogs, seven received it as a bolus, and eight over a period of five minutes. One minute after the bolus, mean arterial pressure dropped to 72% of control and systemic vascular resistance fell to 60% of control. Other cardiac parameters such as rate and cardiac index did not change in this group. In the dogs receiving the IVMP over a five-minute period, the heart rate increased by 23%, while other parameters were unchanged. Five minutes after the injections all cardiac parameters in all 15 dogs returned to the preinjection levels. There were no changes in serum sodium, potassium, magnesium, or total calcium. Electrocardiograms demonstrated no arrhythmias. A possible major finding was seen in the IVMP bolus group, where the ionized calcium fell from 1.49 to 1.18mEq/l, whereas in the dogs receiving the infusion over five minutes, the ionized calcium only decreased from $1.49 \pm .02$ to $1.33 \pm .08$mEq/l. The ionized calcium level returned to normal within five minutes in all of the dogs.

IVMP administration is also fraught with the general problems of chronic, oral corticosteroid use, but special attention needs to be directed toward the possibility of infection and avascular necrosis. While chronic high dose corticosteroids are known to be immunosuppressive, it has been noted that with high dose IVMP, occult infections may rapidly disseminate even after single pulse administration. Garrett, *et al.*,[4] followed 50 patients receiving IVMP pulse therapy; all had autoimmune disorders. Seven developed infections which disseminated from occult sites; two were life threatening. In the latter, one patient had a urinary tract infection and the other had osteomyelitis. None of the 50 patients in Garrett's study developed avascular necrosis.

Susan, *et al.*,[18] followed 146 renal transplant patients who received IVMP and 242 who did not, but who received oral high dose corticosteroids. The incidence of avascular necrosis in the two groups was 4.8% and 5% respectively. Even one dose of one gram IVMP was associated with avascular necrosis. The 28 patients who received HLA identical kidneys and received either low dose or no corticosteroids had no avascular necrosis.

Conclusion

A rapid push of IVMP causes a direct drop in systemic vascular resistance and in blood pressure. Because of this, IVMP should be administered no faster than over a 30 to 60 minute timespan. No evidence has appeared of electrolyte abnormalities or arrhythmias with slow infusions. However, in studies with dogs, ionized calcium dropped significantly with rapid IVMP administration. Anaphylactic or anaphylactoid reactions may occur immediately, but reactions can be delayed. Patients who develop pruritus, bronchospasm, or hives should have the infusion stopped immediately. The usual resuscitative therapies, including epinephrine and fluids, should be readily available. All patients should be observed for 30 minutes after termination of the infusion. Occult infections may disseminate and should be excluded as best as possible with a careful physical examination and laboratory assessment before IVMP use. IVMP is associated with avascular necrosis. Five percent of patients will probably suffer from it, and patients should be made aware of that possibility. ◀

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Illinois
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The Year in Review

1987



Allan L. Goslin, M.D.
1936-1987

Allan Goslin's untimely death three weeks after he was sworn into office as 1987-88 ISMS president cut short a life of community service and medical leadership. This report is dedicated to his vision.

Introduction

Dear Colleague:

AIDS…Teen Health…Malpractice…Medical Discipline…Medicare and Medicaid Costs. These are just a few of the issues which topped Illinois headlines and provided debate for our state and federal policymakers during 1987.

The Illinois State Medical Society represented and advocated your interests and your patients' needs in each of these areas. We educated patients and key public opinion leaders throughout Illinois. We challenged the status quo when we knew health care could be improved. Membership commitment and work within the community laid the groundwork for each of these achievements. As a member of ISMS, you should be proud of organized medicine's efforts and profile on key public health issues.

This report is not a summary of our work this year. It's a series of snapshot capsules focusing on just a few of the major themes in 1987. It offers some perspective on the issues confronting medicine and outlines the steps we took together to meet these challenges.

A final note on the importance of your ISMS membership: we need your continued support to manage the changes and the risks buffeting our profession today. Your dollars build the foundation for essential education and lobbying. But your personal interest and participation are what make those programs work. Our successes rest solidly on the strength and credibility of our collective voice. If after reading this you have any questions about ISMS programs, or want to offer your time and skills, please contact your state medical society.

Sincerely,

Alfred J. Kiessel, M.D.
Chairman of the Board

Edward J. Fesco, M.D.
President



Alfred J. Kiessel, M.D., chairman, ISMS Board of Trustees



Edward J. Fesco, M.D., president, Illinois State Medical Society



Communicating Medicine's Message

"Doctors need to improve their visibility as caretakers of the public health," Bruce Dan, M.D., medical editor of Chicago's WLS Television and senior editor of the *Journal of the American Medical Association*, told the *Illinois Medical Journal* in a February 1987 interview.

And that is just what the Illinois State Medical Society worked to accomplish in its 1987 media relations activities. Medical society spokespersons responded to over 400 requests for information and interviews from print and broadcast reporters. We met with editorial boards of newspapers from Chicago to Carbondale. We appeared on radio and television talk shows. And we previewed key legislative issues for Illinois' state capitol press corps in a special statehouse briefing session.

The topics ranged from Medicaid and Medicare to the lack of obstetrical care in southern Illinois. We talked about AIDS and alcoholism, medical discipline and malpractice. On each and every media request, ISMS tried to find an expert physician spokesperson to represent our point of view. On questions of ISMS policy or activities, the state medical society president served as our official voice in the media.

In 1987, ISMS attacked the separate problems of **medical malpractice reform** and **medical discipline** much as we had two years ago. Educating the public to medicine's perspective again proved to be essential groundwork.

An April news conference kicked off the two-pronged legislative campaign for better medical discipline and medical malpractice reform. Editorial board meetings across Illinois stressed the need for continued reform of medical malpractice laws. Physician spokespersons presented proposals to boost discipline within our own ranks. "An impressive and somewhat surprising effort" was the response we generally received from media representatives after we'd outlined the profession's commitment to bettering medical discipline:

> *The Illinois State Medical Society deserves credit for working toward state legislation that will provide for quicker action against incompetent physicians.... More than anything else, the legislation says that a problem has been recognized and that professionals and legislators are willing to cooperate.... (T)his is once that the system worked the way it should.*
>
> Galesburg Register Mail
> May 27, 1987



ISMS President Edward Fesco is interviewed by WCIA Television, Champaign.



A6 Friday, September 4, 1987

The editorial board of The Pekin Daily Times is composed of publisher Robert W. Marshall and managing editor Thomas J. Trotter.

Opinion labeled "Our opinion" is the opinion of those two individuals.

Other opinions expressed on this page are by the authors of each individual letter, article, column or cartoon.

Our opinion:

Doctor deserves aid in fight against AIDS

It is nice to see the Illinois State Medical Society concerned about things these days other than the high cost of malpractice insurance.

The past two years the society apparently had set its battle against lawyers and the insurance industry as its top priority. This year the society is still concerned with malpractice insurance costs but the issue is no longer No. 1.

Probably because we didn't have to cover and recover the malpractice question, we had a thoroughly enjoyable visit the other afternoon with society president Edward Fesco who was in town to speak to the Tazewell County Medical Society.

Dr. Fesco, after you meet him, is the kind of guy everybody wishes was his family doctor. He is a general surgeon at LaSalle by profession, but this year he is a genuinely concerned man with a mission as he spends much of his time representing the 17,000 members of the state society.

The good doctor wants to awaken the state that AIDS is and will be a big problem in Illinois. He wants to at least begin the educational programs and dialogue necessary in an effort to prevent the spread of the disease especially among our young people.

School will be devastating," he said. He ther expressed the hope that it would not happen.

Parents are the key right now, he says. Parents must realize that with AIDS there no cure. There is only death. With that mind they can undertake the counseling the home that is needed to prevent epidemic.

He also wants community leaders and fellow physicians to help teens who d have strong family supporters by promo and assisting in school based sex educa programs.

Doctors also have to be educated about disease. Fesco doesn't see failure to AIDS patients as a major problem fo profession. Most physicians have atte people through every other epidemic th history and he doesn't see more than th historic few heading for the hills away AIDS patients either.

Fesco can cite chapter and verse how sexually active Illinois teens a figures are readily apparent in the of teen births in the state including girls 14 and under. Figures for teen a also are available but are not as cor many have the operation done away state for reasons of privacy.

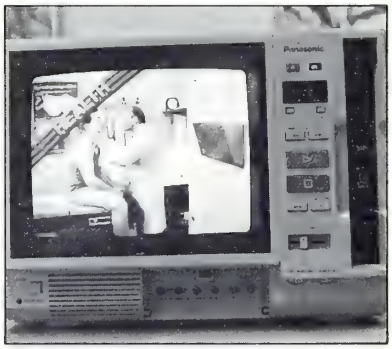
As we said we liked the man. We

The new Illinois law, by toughening state regulatory efforts while helping competent physicans take a more active role in policing their own profession, thus ought to go far toward making Illinois one state where dangerous doctors receive the sanctions their incompetence deserves. We therefore commend the Thompson administration, the Illinois State Medical Society and the General Assembly for cooperating in hammering out this much-needed reform.

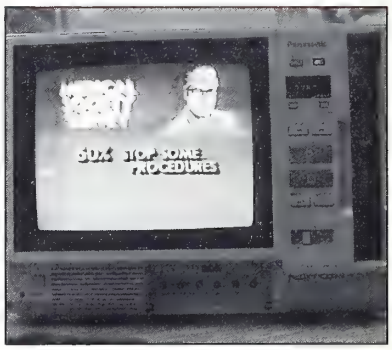
Aurora Beacon News
June 6, 1987

ISMS legislative efforts resulted in passage of a strong Medical Practice Act in 1987 and a shortened statute of limitations for medical malpractice cases involving minors. We did not achieve 100% of our 1987 agenda; caps on noneconomic losses remain on the horizon for the 1989 state legislative session. But media education in 1987 reinforced and broadened organized medicine's case with the media and the public.

In the second half of 1987, ISMS began a major media campaign on **teen health issues**—more specifically, the threat of AIDS for teens who are sexually active and not taking precautions for their health. Illinois teens gave birth to more than 22,000 babies in 1986, and there is little doubt that the problem of teen pregnancy is growing in all corners of our state. ISMS president Dr. Edward Fesco has been straightforward in media interviews and speeches to civic groups. "Several years ago, I, and many of you, would have characterized teen pregnancy as primarily a moral issue," he has told Illinois citizens. "But the vast numbers of pregnant teenagers signify an intense level of sexual activity among today's young. And with the spread of the sexually-transmitted AIDS epidemic, this moral issue must now be considered a public health issue as well."



Dr. Arvind Goyal told WMAQ viewers about the stresses faced by obstetricians as a result of the malpractice crisis in a special feature on the 1987 ISMS membership survey and legislative package.



Television coverage of the 1987 legislative package brought the ISMS survey findings to the attention of the public.



ISMS Trustee Ronald G. Welch was one of many leaders to participate in spokesperson training.



Alfred J. Clementi, M.D., ISMS trustee and chairman of the Governor's Task Force on Medical Discipline, debates medical malpractice on WBBM's *Common Ground*. Shown (L-R) are moderator Phil Ponce, Dr. Clementi, plaintiff attorney Phillip Corboy, Robert Hudek of the Coalition on Consumer Rights and defense attorney Maurice Garvey.



1986-87 ISMS President Jere Freidheim shares facts on the medical malpractice crisis with WMAQ television viewers.



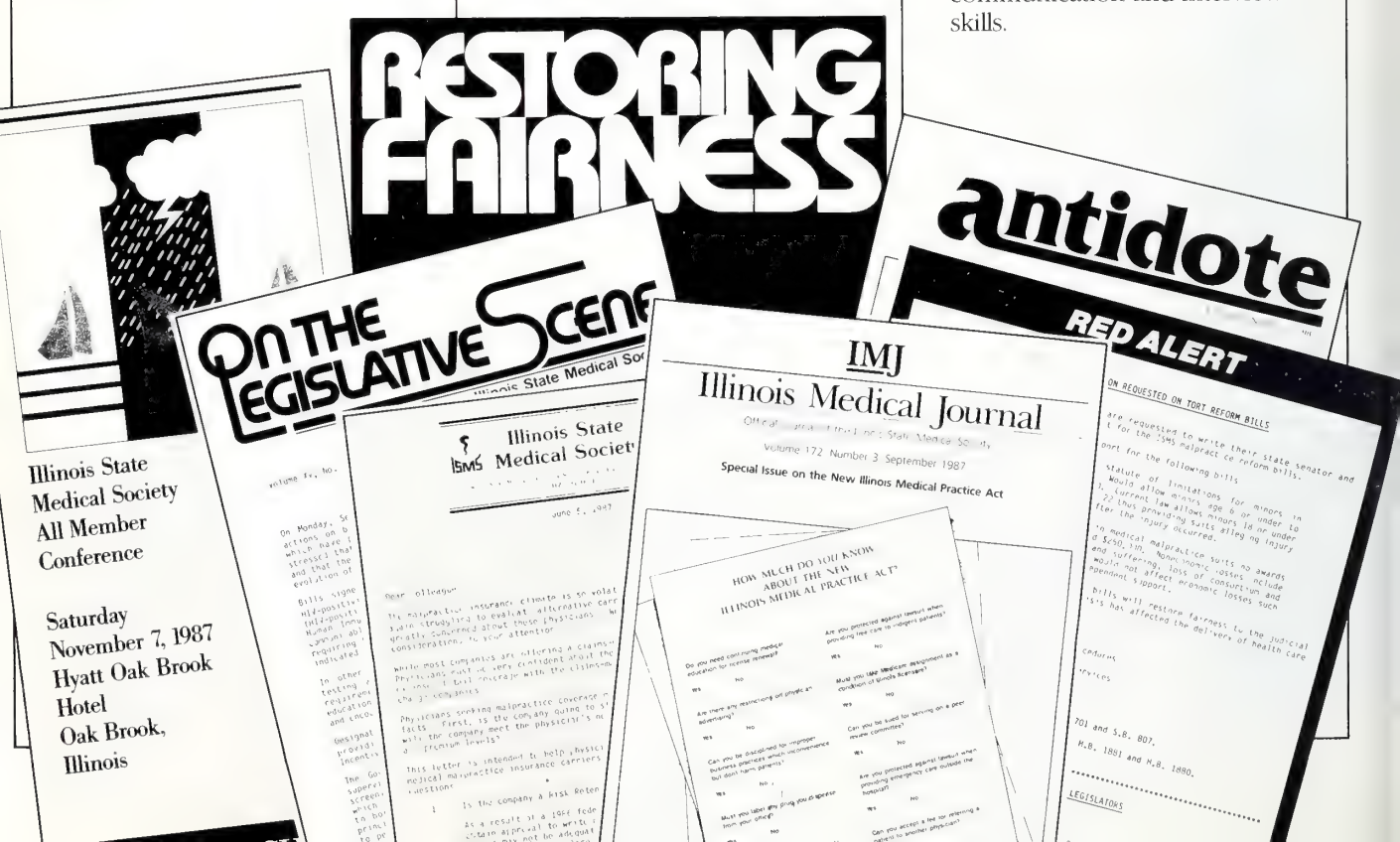
ISMS President Edward J. Fesco addresses the Decatur Kiwanis Club.

Reaching Colleagues

ISMS member physicians throughout Illinois are on the front line with the public and public policymakers. Timely, pertinent communication between the medical society and our membership is crucial. In 1987, ISMS met this need in several ways:

- ***On the Legislative Scene*** kept ISMS member physicians on top of fast-moving legislative action in the state capitol. "Red Alerts" on such issues as mandatory Medicare assignment, caps on noneconomic damage awards and the new Medical Practice Act sparked physician contact with local legislators and media representatives at key moments.
- ***The Illinois Medical Journal*** devoted special issues to the new Illinois Medical Practice Act as well as local developments in AIDS treatment. Illinois' new organ transplant law and detection of elder abuse were among other *IMJ* cover stories this year.
- ***1987 President's Tour:*** ISMS Presidents Jere E. Freidheim, M.D., and Edward J. Fesco, M.D., shared responsibility for the President's Tour in calendar year 1987. Their themes were similar: the need for long-term commitment by Illinois physicians to continuing medical malpractice reform. Both highlighted the need for physician involvement in local elections to assure that legislators understand the needs and problems of medical practice in Illinois today. Only grassroots contact and election campaign assistance by doctors will assure that medicine's voice is heard on key votes in Illinois' General Assembly.
- ***Recognition of Public Service:*** The ISMS Public Service Awards were initiated in 1987 to reward and encourage community service benefitting the public health. One physician and one nonphysician are eligible to receive the award each year. The first recipient, Earl Stockdale, M.D., Rock Island, was honored for his work to organize a physician volunteer network to care for the medically indigent in Rock Island County. House Minority Leader Lee Daniels (R-Elmhurst) was the recipient of the nonphysician award recognizing his work in support of medical malpractice reform. Also this year, legislative counsel Saul Morse, Springfield, was recognized for his service to the Society with a special Chairman's Award.
- ***Programs for Young Physicians:*** The Society augmented efforts to assist young physicians with a new Young Physicians Committee reporting to the Council on Public Relations and Membership Services.

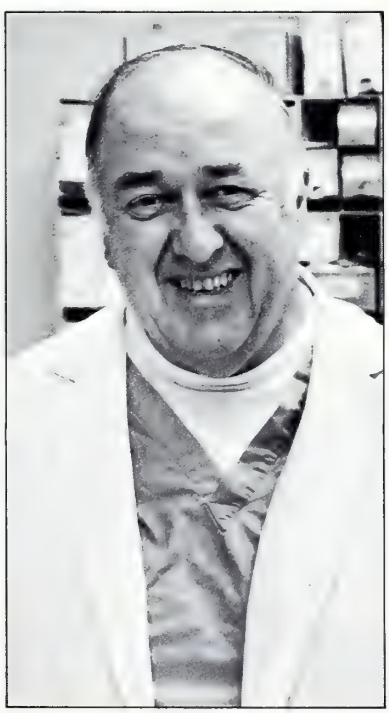
  In November, members of the ISMS Medical Student Section (MSS) gained how-to advice on preparing for residency interviews at a new MSS seminar. Residency program directors presented their needs and a representative from the AMA Women in Medicine Project discussed what students should seek from a residency program. Students gained an insider's view of the National Resident Matching Program and a hands-on opportunity to polish communication and interview skills.



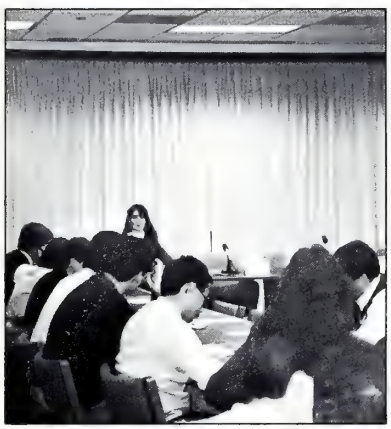
- ***All Member Letters***—ISMS Board of Trustees Chairman Alfred J. Kiessel, M.D., communicated directly with the Society's 17,000 members on issues of urgent concern. His letters covered a wide range of topics. One dissected Governor Thompson's tax proposal—and its impact on Medicaid reimbursement. Another reported on trends in medical malpractice coverage—including new entities, such as risk retention groups and new concepts, such as channeling.

Member communication will continue to be a major focus in the years ahead. A full-fledged communications study to investigate cost effective ways to improve the reach and relevance of our message is now underway.

This communications study, and any resulting improvements, will include the input of members throughout the state. An all member survey, (see box) coupled with focus groups of physician volunteers who personally shared their information needs, are the basis on which ISMS will shape its future communications.







Participants at the ISMS Medical Student Section seminar on preparing for residency interviews.

Membership Survey Charts the Course

In January 1987, ISMS members were asked to complete a detailed mail survey, conducted by Market Opinion Research, on their interests and priorities for organized medicine. Their tabulated responses and spontaneous comments helped to structure the Society's planning for the year.

Some highlights:

- Over 40% of the membership rates malpractice issues at the top of their list of urgent matters facing medicine.
- Concerns rated next are new Medicare regulations, physician supply issues and alternative delivery systems.
- Medical practice is changing in response to the medical malpractice situation—78% of respondents are ordering more tests.
- Availability of care is shrinking as well—52% of ISMS members responding have discontinued some procedures and 39% have limited their use of new techniques.
- Representation in the state capitol continues to be considered a primary membership benefit.
- Interest in a reformatted communications program is high: 59% of the membership would prefer a socioeconomic emphasis in the Society's flagship publication.

Reaching Public Opinion Leaders

ISMS worked hard in 1987 to communicate with key opinion leaders about public health issues. We spoke out in formal and informal settings, voicing physician perspectives on subjects ranging from medical malpractice and health care cost containment to infant mortality.

During 1987, physician leaders continued to debate the medical malpractice crisis with attorneys and consumer groups around the state. Fred Z. White, M.D., chairman of the Illinois State Medical Inter-Insurance Exchange, faced off with consumerist Ralph Nader at a Rockford seminar in May. Said Dr. White to Mr. Nader's assertion that Illinois physicians pay more for their autos than for medical malpractice insurance, "I certainly wouldn't—and couldn't afford—to pay up to $80,000 for my car, even if it did have airbags!"

Later in the year, Dr. White again represented Illinois physicians at a health care cost containment forum of Chicago's top financial and insurance benefits executives. He argued that cost containment moves must be carefully thought out and executed so that they do not jeopardize quality in the day-to-day delivery of health care.

In November, the Illinois State Medical Society participated in a "point-counterpoint" presentation before the Illinois State Bar Association's young lawyers' division. Dr. Robert Hamilton, ISMS trustee and chairman, Illinois State Medical Insurance Services, explained medicine's view of the malpractice crisis. He also represents medicine's perspective on the Illinois State Bar Association's Interprofessional Relations Committee.

ISMS President Dr. Edward J. Fesco testified on infant mortality at congressional hearings in Springfield. He told policymakers of medicine's growing concern with Medicaid's inadequate reimbursement rate for physicians delivering babies of indigent mothers. He outlined the difficulties these mothers encounter in seeking medical care. Many bring complex medical problems to the physicians from whom they seek assistance. Malnourishment and other complications are common. The reimbursement rate from Medicaid, Dr. Fesco asserted, is usually less than 50% of physicians' regular charges. As such, it often fails to cover even the cost of medical malpractice insurance premiums and other office overhead.

Dr. Fesco was joined in his testimony by Harrisburg physician Cynthia Fraed, who told members of the House Select Committee on Children, Youth and Families why she was forced to give up delivering babies of mothers dependent on Medicaid.



ISMS President Edward J. Fesco participates in congressional hearings on infant mortality. Two ISMS obstetricians, Cynthia Fraed, Harrisburg, and James Singleton, Springfield, also testified.



ISMIE Board of Governor's Chairman Fred Z. White, M.D., debates Ralph Nader in Rockford.



Your Voice in the State Legislature

Medicine's first lobbyists are the physician members of ISMS. The Society's professional team is the doctors' front line in the battle to keep health care quality at the top of legislators' crowded agenda. 1987 was a year when the issues were numerous, and were also among the most serious to confront the profession. More than 400 pieces of legislation affecting health care and medical practice were introduced in the General Assembly in 1987. Among them:

- The Illinois Medical Practice Act came up for sunset review.
- Proponents of mandatory Medicare assignment brought their case before the legislature.
- Outstanding medical malpractice reforms were under consideration.

The Medical Practice Act defines the quality of health care in Illinois by stipulating educational requirements, unacceptable activities and enforcement procedures. The Illinois General Assembly scrutinized the total Act in 1987, as part of a legislative "sunset review."

ISMS had worked hard and long to improve the medical discipline system, and suggested several reforms for incorporation into the Act. The discipline provisions eventually adopted in conjunction with the new law embodied recommendations of the Governor's Task Force on Medical Discipline, chaired by former ISMS Board of Trustees Chairman Dr. Alfred J. Clementi. As a result of these efforts, Illinois has become a model state in medical discipline.

At the same time, legislators considered strident calls for mandatory Medicare assignment in Illinois. The state of Massachusetts had recently passed a law under which Medicare assignment had become a condition of licensure, and consumer groups supported a similar bill for Illinois.

And two crucial medical malpractice reforms—the statute of limitations for minors and caps on noneconomic damages—were under consideration.

The 1987 Illinois legislature passed a solid, progressive Medical Practice Act, responsive to the needs of the profession and the concerns of the public. Mandatory Medicare assignment was defeated. The statute of limitations for medical malpractice cases involving minors was reduced in a fair, even-handed fashion. A limit of eight years now will apply to any medical malpractice suit involving a minor—a significant improvement on the more than 20 years in which a suit could be filed prior to passage of the new law.

The ISMS physician leadership vowed to work toward future consideration of caps on noneconomic awards, election of lawmakers willing to listen to medicine's point of view and meaningful input in the legislative process.



An historic moment: Illinois Governor James R. Thompson signs the new Illinois Medical Practce Act. Looking on (L-R) are Drs. Robert C. Hamilton, Edward J. Fesco, Alfred J. Kiessel, Fred Z. White, and Alfred J. Clementi.



IMPAC Chairman George T. Wilkins, Jr., M.D., exhorts the troops.

Health Care Economics

Many physicians have been affected by the increasing influence of alternative health care delivery systems. ISMS responded with a technical review service for members, providing objective comment on contracts proposed for physician services. As a result, Illinois doctors became more fluent in "hold harmless" clauses, "stop loss" provisions and "capitation schedules."

The Society's contract review program was expanded with a new column in *IMJ*, "The Informed Physician." ISMS also heightened emphasis on the service, which is available to members only. Contract reviews provide objective comment on proposed HMO, IPA and PPO physician employment agreements. Reviews are intended to identify areas for further inquiry or discussion. While they are no substitute for legal advice, contract reviews provide insight into common concerns and can enlighten physicians seeking to find their way through a confusing array of contracting alternatives.

The Society also regularly communicates with the membership on economic issues, and attempts to interpret government regulations affecting medical practice. For example, ISMS cosponsored a series of 26 seminars on Medicare in cooperation with Blue Cross/Blue Shield, the Medicare Part B carrier, in response to changes in Medicare regulations. Society staff fielded hundreds of member inquiries about Medicare and Medicaid billing problems as part of a continued commitment to membership support in these areas.



Managing Malpractice Risks

The number of claims filed against physicians continued to decline in 1987—further dramatic evidence that the 1985 medical malpractice reforms had brought tangible relief. But while the number of frivolous suits fell drastically after enactment of the 1985 reforms, the size of damage awards—especially for noneconomic factors such as pain and suffering—continued to escalate.

During the 1987 session of the General Assembly, ISMS sought legislation capping noneconomic damages in medical malpractice awards and shortening the statute of limitations for cases involving minors. The legislature did not agree with the first proposal, but the second did become law.



The plaintiff and his attorney make their case.

The Society has not abandoned its quest for a lasting solution to the malpractice problem, and especially for caps on pain and suffering awards. Through its Political Action Committee, ISMS is now girding for the 1988 elections, supporting those candidates who appear to be receptive to further legislative reforms.

The 1987 All Member Conference, "Managing Change," featured a mock malpractice trial with a jury of Illinois citizens to dramatize the obvious and hidden factors at play in a trial for medical malpractice. The mock trial provided a fascinating illustration of the legal system at work. Breakout sessions were another highlight of the meeting. These roundtables enabled physicians to discuss loss prevention concerns with colleagues in their specialties.

Through Illinois State Medical Insurance Services, Inc., and the Illinois State Medical Inter-Insurance Exchange, ISMS continued to build risk reduction/loss prevention programs:

- Educational videotapes and other materials were designed to assist physician loss prevention efforts. "Managing Your Risk in the Office," focuses on patient communication problems which lie beneath so many medical malpractice suits. "Managing Your Risk at the Hospital," provides advice on working with the health care team, and guidelines for consultations, referrals and informed consent.
- Risk reduction seminars for physicians based on local loss data were held across the state.
- Hundreds attended risk reduction seminars for hospital medical staffs and physician office staffs.
- Printed material was distributed through the *Illinois Medical Journal, Antidote,* and *Exchange Commentary.*

ISMIS also continued to refine its data base and review loss experience in specific specialties to identify patterns and develop advisory guidelines for physicians.



Jurors assess the evidence.



The nurse: unshakeable testimony?



Testimony from an expert.

Helping Colleagues

In 1987, two ISMS programs continued to offer physicians support, counseling and guidance during difficult times in their lives and careers. These programs operate for individual members. Both are confidential and have no disciplinary or reporting function.



(312) 580-2499

The ISMS Impaired Physician Program fielded some 100 calls from physicians, their families or others seeking help or information this year. The addition of a full-time medical director to lead the program, facilitated by a grant from the Illinois State Medical Inter-Insurance Exchange, enables the Society to help physicians throughout Illinois who are dependent upon alcohol or drugs, or physically or mentally disabled.

Violet Eggert, M.D., a certified addictionologist, has joined ISMS to shepherd the impaired physician program. She is available to help individual physicians and to assist hospitals and county medical societies seeking to establish local impaired physician programs.

The ISMS Physician Support Group helps physicians engaged in malpractice litigation to cope with the stress of being sued. Physicians who react to the stress of litigation are not ordinarily impaired. They are generally well-functioning physicians confronted with a major life crisis. For this reason, the program is designed to provide an informal and sympathetic listener rather than therapeutic intervention.

Both the Physican Support Group and the Impaired Physician Program can be reached by dialing the 24-hour "Physician Help Line" (312)580-2499.

Education

Child abuse detection, AIDS, physician dispensing and technical advice on closing a medical practice were among major physician education projects in 1987.

Child Abuse Education

Last year, more than 70,000 cases of child abuse—including some 80 fatalities—were investigated by the Illinois Department of Children and Family Services (DCFS).

To help physicians recognize abuse and comply with legal requirements for reporting of suspected abuse and neglect, the Illinois State Medical Society created a special Ad Hoc Committee on Child Abuse Education. With the assistance of a grant from DCFS, ISMS embarked upon a statewide physician education campaign.

Seminars were conducted by physician experts, and representatives of both the legal community and DCFS. ISMS produced publications and audiotapes for distribution to primary care physicians:



- "Child Abuse and Neglect: The Physician's Role" is designed to help doctors identify children who may be susceptible to abuse or neglect, diagnose abuse-related injuries and perfect interviewing techniques. Reporting requirements, temporary custody provisions and referral resources are also detailed.
- "Dealing with the Disabled Infant—a Physician's Guide," was published in response to a new law under which depriving severely handicapped infants of medical care can be the legal equivalent of child abuse. Educational materials help physicians identify legally disabled infants and "medical neglect," and outline appropriate procedures. Information concerning the state's perinatal network and other resources is included.

AIDS Education

ISMS responded to the AIDS epidemic with a series of educational efforts during 1987. Clinical experts conducted a series of seminars across the state on epidemiology, diagnosis and prevention of AIDS and AIDS-related conditions. Under the direction of the ISMS Ad Hoc Committee on AIDS, the Society developed resource material, including a guide for physicians seeking to educate and counsel patients. Precautions to avoid contracting the virus during the course of patient care were outlined, as well as advice for doing invasive procedures. A resource directory listed AIDS-related organizations and services, including "hotlines," referral and counseling services.

ISMS also made physician experts available to the Illinois General Assembly to enable proper consideration of medical issues during public policy debate.

Physician Dispensing

The new Illinois Medical Practice Act contains strict prescribing, recordkeeping and dispensing requirements for controlled substances. ISMS undertook a major educational campaign to ensure that its members were aware of their responsibilities under the law. Written materials and audiotapes were developed to teach physicians about record keeping and reporting requirements. Member seminars provided techniques to recognize and thwart drug diversion schemes, and helped physicians develop patient education skills.

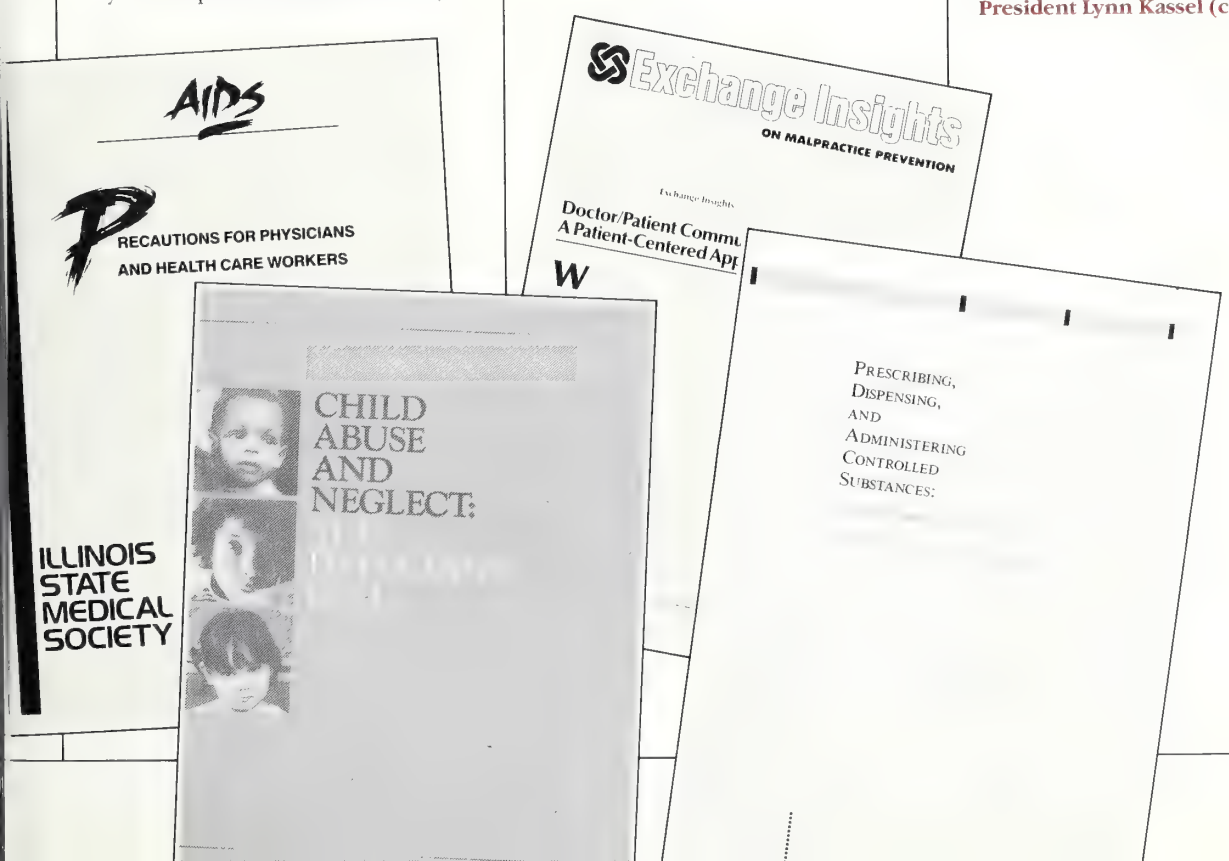
Closing a Practice

The ISMS Medical-Legal Council produced a booklet to assist spouses and family members of deceased physicians faced with the task of closing a medical practice unexpectedly.

The brochure outlines steps to advise and help patients make a transition to a new physician. Confidentiality of medical records and proper disposal of prescription pads and medications on the premises are covered. Proper notice to the malpractice insurer and other entities with legal ties to the practice and dissolution of a medical corporation are described.



ISMS Auxiliary public education efforts in adolescent health included an adolescent sexuality workshop which drew more than 100 participants. Shown above are the program chairmen, Joanne Woiteshek, R.N. (L) and Nancy Moore, R.N. (R) with ISMSA President Lynn Kassel (center).



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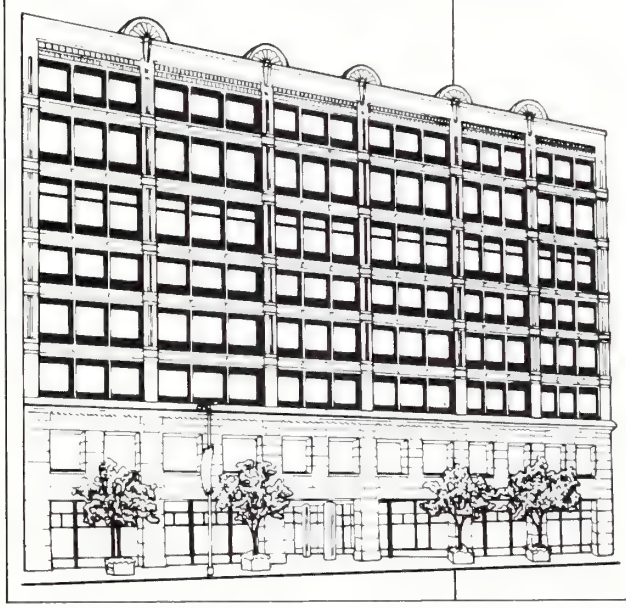
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Hiring Credentialed Employees Can Lessen Malpractice Exposure

By Donald A. Balasa, J.D., C.A.E.,
Assistant Executive Director, Staff Attorney
American Association of Medical Assistants

Articles and seminars on how to reduce the risk of medical malpractice liability have become legion in recent years. There is one dimension of the question, however, that has not been given extensive treatment—the legal advantages of hiring credentialed employees.

It is necessary, first of all, to define the two types of credentialing most commonly found in the allied health area.

Licensure is a state credential *required* for legal practice. In Illinois, for example, no "technician, nurse, or other assistant" acting under the supervision of a person licensed under the Medical Practice Act or the Podiatry Act shall administer radiation to human beings unless "accredited" (a term sometimes used interchangeably with "licensed") or exempted by the Department of Nuclear Safety. Similarly, a recently enacted amendment to the Illinois Clinical Laboratory Act empowers the Department of Registration and Education to promulgate regulations detailing the educational and experience requirements for laboratory technologists and technicians (although not assistants) performing functions in a physician's office laboratory.

Certification is a *voluntary* credential, usually granted by a nongovernmental entity, that gives evidence of a certain degree of skill and knowledge. Medical assistants, although not licensed for their full domain of practice, may attain the Certified Medical Assistant (CMA) credential of the American Association of Medical Assistants by meeting the necessary prerequisites and successfully completing the certification examination.

Aside from obvious benefits such as increased productivity, what are the advantages from a malpractice perspective of hiring credentialed employees?

Because the physician is responsible for the negligent deeds of all allied health practitioners acting within the general scope of delegated authority, it is essential that the doctor be aware of the abilities and limitations of all members of the staff—including those who function in an administrative rather than a clinical capacity. The mere fact that an employee is licensed and/or certified and is performing procedures tested in the licensure/certification process does not exonerate the physician from delegating only those functions which can be performed by the employee in a reasonably competent manner. This oversight responsibility of the physician is especially crucial if there are no continuing competence requirements (*i.e.*, mandatory continuing education, retesting, peer review) established by the allied health practitioner's credentialing body.

If all other things are equal, however, and a doctor and employee(s) are named as defendants in a malpractice action, there are legal advantages to both the physician and the employee if the employee is currently certified in the applicable allied health profession.

Utilizing certified personnel is *prima facie* evidence that the physician is exercising due care in the role of delegator and coordinator of the health care delivery unit, and could spell the difference between a favorable and unfavorable finding or settlement. This is especially true if the alleged negligence involved a procedure that was tested on the employee's certification examina-

tion. Proof of the employee's preparation for and passing of the test would lend credibility to the doctor's assertion that the procedure at issue was not delegated carelessly or capriciously.

Certification also offers many benefits in the malpractice context to the allied health worker. Even though the physician is liable for the malpractice of staff, each individual employee is also liable for negligent acts or omissions. Attainment and maintenance of certification demonstrates commitment to professional excellence, and could rebut a claim that the employee was undertaking duties for which she/he was not qualified. If the alleged malpractice arose from an emergency or a situation which required some degree of independent judgment, certification by a recognized testing body would attest to the individual's depth of knowledge in the theoretical as well as the practical aspects of allied health care.

Medical assisting certification by the American Association of Medical Assistants is an example of an allied health certification program that would be of inestimable value in court. The content of the examination is based on a recent occupational analysis of the medical assisting profession derived through the Developing A Curriculum (DACUM) process, and is representative of how medical assisting is currently practiced in the United States. A content outline has been devised by the certifying board of the AAMA which gives candidates and other interested parties more detailed information on what functions and areas of knowledge are tested. Moreover, the National Board of Medical Examiners, a reputable and influential credentialing body for health care professionals, administers the test for the certifying board.

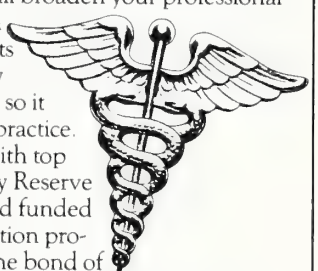
In conclusion, both physicians and allied health personnel should give serious regard to the legal advantages of either hiring or being a certified employee. Medical assistants interested in the CMA credential should contact the American Association of Medical Assistants, 20 N. Wacker Drive, Suite 1575, Chicago, IL 60606, (312) 899-1500.

Further information regarding certification or recertification can be obtained by contacting Cheryl Hutchison, CMA, ISMA, president, 53 Lockhaven, Granite City 62040; or the public relations co-chairpersons: Lesa B. Hildebrand, Ed.M., CMA-C, Triton College, 2000 Fifth Avenue, River Grove 60171; or Lucille Perce, CMA-C, 22W384 Teakwood, Glen Ellyn 60137. ◀



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GUIDE TO CONTINUING MEDICAL EDUCATION

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

January

Internal Medicine/Family Practice/GP

AIDS: Role of the Practitioner
For: Interested physicians. Symposium, January 26, Drake Hotel, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611, ISMS and AMA. **Fee:** $40. Reg. Limit: 200. **Credit:** Category 1: 3 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Year in Internal Medicine
For: Interested physicians. Course, January 27-29, Drake Hotel, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611, ISMS and AMA. **Fee:** $275. Reg. Limit: 300. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cellular Mechanisms of Insulin Action-Diabetes Mellitus
For: Interested Physicians. Lecture, January 11, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central, Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5716.

February

Ophthalmology

Laser Treatment for Common Fundus Diseases
For: Ophthalmologists. Workshop, February 12-13, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465A WARF Bldg., 610 Walnut Street, Madison, WI 53705, and Dept. of Ophthalmology, School of Medicine, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** 48. **Credit:** Category 1: 14 hours; other: University of Wisconsin CEU's: 14 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Pathology

Histological Determinance of Breast Cancer Risk
For: Pathologists. Lecture, February 8, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5716.

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, February 26-28, Holiday Inn, Mart Plaza, Chicago. **Sponsor:** University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** 150. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

March

Hematology/Oncology/Internal Medicine

Advances in Autologous Bone Marrow Transplant
For: Hematologists, oncologists, and internists. Lecture, March 19, Marriott Oakbrook, Oak Brook, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $20. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Internal Medicine

Early Intervention in Acute Myocardial Infarction
For: Cardiologists and internists. Lecture, March 16, Holiday Plaza Complex, Matteson, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $65. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology

Fluorescein Angiography Workshop
For: Ophthalmologists. Workshop, March 11-12, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** 35. **Credit:** Category 1: 14 hours; other: University of Wisconsin CEU's: 14 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Pathology

Neoplastic Lymph Node Pathology
For: Pathologists. Seminar, March 14, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Pathology Dept., Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5716.

Radiology

Imaging Modalities in the Chest and Abdomen
For: Radiologists. Symposium, March 20-25, Maui, Hawaii. **Sponsor:** Loyola University Stritch School of Medicine, Division of CME, 2160 S. First Avenue, Maywood, IL 60153. **Fee:** $485. **Reg. Limit:** 200. **Credit:** Category 1: 20 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3236.

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In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

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January 18	MacNeal Hospital	*Berwyn*
January 25	University of Chicago Hospital	*Chicago*
To Be Announced	Ambutal	*Crystal Lake*
To Be Announced	Copley Memorial Hospital	*Aurora*
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To Be Announced	Highland Park Hospital	*Highland Park*
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